

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA :
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 v. : Crim. No. 98-357 (EGS)
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 RUSSELL EUGENE WESTON, JR. :

ORDER

Russell Eugene Weston, Jr. is charged in a six-count federal indictment with the murders of United States Capitol Police Officers Jacob J. Chestnut and John M. Gibson, while they were engaged in their official duties as federal law enforcement officers; one count of attempted murder of United States Capitol Police Officer Douglas B. McMillan, while he was engaged in his official duties as a federal law enforcement officer; one count of carrying and using a firearm during and in relation to a crime of violence; and two counts of carrying and using a firearm during and in relation to a crime of violence and causing a death thereby. The crimes alleged in the indictment occurred on July 24, 1998. On April 22, 1999, after hearing testimony from Court-appointed psychiatric expert Dr. Sally Johnson, this Court found Weston not competent to proceed to trial, pursuant to 18 U.S.C. § 4241(d). While a more detailed recitation of the protracted procedural history of this case need not be given here, the Court notes the extensive efforts that have been made to bring this case to resolution and recognizes the officers' colleagues' and family members' desire for closure in this case.¹

¹ For the convenience of the court and others who will be involved in future proceedings related to Mr. Weston, the Court has attached the following prior orders and opinions in this case: (1) United States v. Weston, 134 F. Supp. 2d 115 (D.D.C. 2001); (2) United States v.

On November 15, 2004, this Court heard testimony from Dr. Johnson regarding the likelihood that Mr. Weston would attain the mental competency to stand trial for the above charges. Dr. Johnson testified that following more than two years of rigorous medical treatment, it was her expert opinion that Mr. Weston remains incompetent to stand trial and she no longer believes there is a substantial likelihood that Mr. Weston's competency will be restored in the foreseeable future.

Therefore, pursuant to 18 U.S.C. § 4241(d), it is hereby

ORDERED that, based on the evidence adduced at the November 15, 2004 hearing, the exhibits admitted into evidence at that hearing, and the arguments of counsel at that hearing, the defendant is now subject to the provisions of 18 U.S.C. § 4246 in view of this Court's determination that, although there remains a possibility that the defendant's competence will ultimately be restored, the defendant's mental condition has not yet so improved as to permit the criminal trial in this matter to presently proceed; and it is

FURTHER ORDERED that, in accordance with apposite legal precedents, see, e.g., Greenwood v. United States, 350 U.S. 366, 375 (1956); United States v. Ecker, 78 F.3d 726, 728-31 (1st Cir. 1996), the indictment in this matter shall *not* be dismissed and shall remain pending throughout the course of (at the least) any subsequent 18 U.S.C. § 4246 proceeding(s) and any subsequent period(s) of civil commitment ordered by the Court for the district in which the defendant is confined ("the § 4246 Court") and will continue to serve as a detainer against the defendant; and

Weston, 255 F.3d 873 (D.C. Cir. 2001); (3) United States v. Weston, 211 F. Supp. 2d 182 (D.D.C. 2002); (4) United States v. Weston, 260 F. Supp. 2d 147 (D.D.C. 2003); (5) Court Order of Mar. 16, 2004; and (6) United States v. Weston, 326 F. Supp. 2d 64 (D.D.C. 2004).

is it

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the provisions of 18 U.S.C. § 4246(e), which authorize the director of any facility in which a person is hospitalized pursuant to § 4246(d) to certify that the person has "recovered from his mental disease or defect to such an extent that his release would no longer create a substantial risk of bodily injury to another person," the director of any such facility shall promptly notify this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (listed below) of any such certification as this Court hereby provisionally **DECLARES** its intention to re-assume custody of the defendant in order, *inter alia*, to assess the defendant's competency for trial on the still-pending indictment; and it is

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the provisions of 18 U.S.C. § 4247(e)(1)(B), which direct the director of the facility in which a person is hospitalized to prepare "annual reports concerning the mental condition of the person and containing recommendations concerning the need for his continued hospitalization," the director of any such facility shall promptly submit all such reports to this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (who may, in turn, release such reports only to the family members of the two deceased federal law enforcement officers for their review only); and it is

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the provisions of 18 U.S.C. § 4246(d), which direct the Attorney General to "make all reasonable efforts" to cause the State in which a § 4246 civil committee was domiciled to "assume responsibility for his custody, care, and treatment," the Attorney General and its agent the federal Bureau of Prisons shall promptly inform this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (listed below) if, at any point after a § 4246 hearing, a request is made of a State to assume responsibility for the defendant and, at any subsequent stage, a State actually assumes such responsibility for the defendant; and it is

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the provisions of 18 U.S.C. § 4246(e), which direct the § 4246 Court to hold a hearing upon motion of the attorney for the Government if the director of the facility in which the civil committee is hospitalized certifies to the § 4246 Court that the person has "recovered from his mental disease or defect to such an extent that his release would no longer create a substantial risk of bodily injury to another person," the § 4246 Court is asked to consider promptly informing this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (listed below) of any such director's certification as this Court hereby provisionally **DECLARES** its intention to re-assume custody of the defendant in order, *inter alia*, to assess the defendant's competency for trial on the still-pending indictment; and it is

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the provisions of 18 U.S.C. § 4247(h), which state that, "[r]egardless of whether the director of the facility in which a person is hospitalized has filed a certificate pursuant to the provisions of subsection (e) of section . . . 4246," counsel for the person may, at any time during such person's hospitalization file with the § 4246 Court "a motion for a hearing to determine whether the person should be discharged," the § 4246 Court is asked to consider promptly informing this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (listed below) of any such motion; and it is

FURTHER ORDERED that, in light of (1) the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter; (2) the provisions of 18 U.S.C. § 4246(e)(1)(B), which direct the director of any facility in which a person is hospitalized to prepare "annual reports concerning the mental condition of the person and containing recommendations concerning the need for his continued hospitalization;" and (3) the facts that Dr. Sally Johnson has served as the defendant's evaluator for over six years (since October of 1998); the defendant has demonstrated a reluctance to cooperate with other evaluators; and Dr. Johnson has expressed a willingness to continue in her role as evaluator, the Court **RECOMMENDS** that the director of the facility in which the defendant may ultimately be hospitalized retain Dr. Johnson for purposes of any and all subsequent § 4246(e)(1)(B) annual reports; and it is

FURTHER ORDERED that, in light of the pending criminal indictment and this Court's continuing jurisdiction over the still-pending criminal matter and in light of the possibility that the defendant's competency may ultimately be restored during the pendency of any subsequent hospitalization pursuant to 18 U.S.C. § 4246, the § 4246 Court is asked to consider promptly informing this Court, defense counsel, and the Government attorneys in the jurisdiction in which the defendant's indictment is still pending (listed below) of any such competency developments.

FURTHER ORDERED that this Order be placed in the defendant's permanent administrative file and that this Order accompany the defendant to any facility or hospital.

Date: November 22 , 2004

Signed by: EMMET G. SULLIVAN
UNITED STATES DISTRICT JUDGE

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coordinator for the financial statement closing process, and therefore, he had significantly more responsibilities than the five members of his group. Nor is plaintiff similarly situated to Klein, his supervisor, because there is no evidence that Klein “dealt with the same supervisor, [was] subject to the same standards, and . . . engaged in the same conduct” as plaintiff without any differentiating circumstances. *Phillips*, 937 F.Supp. at 37.

Plaintiff also seeks to compare his treatment with that of the other grade 15 supervisor, Laura Rosenberg. While both plaintiff and Rosenberg reported to the same supervisor, they did not have the same responsibilities with respect to the closing process and therefore they cannot be deemed similarly situated with respect to their performance evaluations. Plaintiff maintained complete responsibility for the 1997 closing process and all the associated administrative duties. (Def.St. ¶¶ 9, 12; Def.Ex. 5 (Mack Dep. at 76, 85).) Plaintiff testified that Rosenberg did not deal on a day-to-day basis with the people involved in the process, and while she provided some technical input, she had no administrative duties. (Def.St. ¶ 10; Def.Ex. 5 (Mack Dep. at 106).) The reason stated in plaintiff’s evaluation for the “unsatisfactory” rating is that plaintiff did not fulfill his responsibility as a supervisor to inform management if the closing process situation and delays were getting “out of control.” (Def.Ex. 11; *see also* Pl.Ex. 7 (Klein Aff. at 3).) While there may well have been problems beyond plaintiff’s control, Klein’s complaint was that plaintiff did not inform Klein or Schneider of the magnitude of the problems so that they could take appropriate action, and he instead learned about the problems when an “important customer” complained. (*Id.*)

Plaintiff has not cited to any evidence that Rosenberg, the staff analysts, or anyone else had the same level of responsibility with respect to the closing process as he had or that they failed to fulfill their responsibility to the same extent as he had. Therefore, none of these individuals was similarly situated so that their receipt of more favorable evaluations does not give rise to an inference of discrimination.⁷

CONCLUSION

For the foregoing reasons, the Court concludes that plaintiff cannot establish any element of a *prima facie* case of disparate treatment on the basis of a perceived disability. Accordingly, judgment is entered for the defendant. A separate Order accompanies this Opinion.



UNITED STATES of America

v.

**Russell Eugene WESTON,
Jr., Defendant.**

No. CRIM. A. 98-357(EGS).

United States District Court,
District of Columbia.

March 6, 2001.

After remand of decision upholding Bureau of Prisons (BOP) determination that antipsychotic medication could be administered to pretrial detainee alleged to have killed Capitol police officers, 206 F.3d

7. Given the Court’s conclusion that plaintiff cannot establish a *prima facie* case, it need

not address whether defendants’ reasons for the unsatisfactory evaluation were pretextual.

9, the District Court, Sullivan, J., held that government would be permitted to treat defendant involuntarily with antipsychotic medication as such treatment was medically appropriate and essential in order to render defendant non-dangerous based on medical/safety concerns and to restore defendant's competency to stand trial.

Order in accordance with opinion.

1. Constitutional Law ⚖️262

Pretrial detainee possessed a significant liberty interest in avoiding unwanted antipsychotic medication protected by the substantive component of the Due Process Clause of the Fifth Amendment. U.S.C.A. Const.Amend. 5.

2. Mental Health ⚖️436.1

Government bore burden of proving by clear and convincing evidence justifications for treating pretrial detainee involuntarily with antipsychotic medication. U.S.C.A. Const.Amend. 5.

3. Mental Health ⚖️436.1

Government would be permitted to treat defendant involuntarily with antipsychotic medication in order to render defendant non-dangerous based on medical/safety concerns and to restore defendant's competency to stand trial for killing Capitol police officers; considering less intrusive means, antipsychotic medication was the only therapeutic, medically appropriate treatment for defendant's illness, notwithstanding its potential side effects, and defendant could be medicated without impermissibly infringing on his ability to receive a fair trial. U.S.C.A. Const.Amend.5.

4. Mental Health ⚖️436.1

Psychiatrist can ethically treat solely to render a defendant competent to stand trial, even if a capital case.

Ronald L. Walutes, Jr., U.S. Attorney's Office, Civil Division, Washington, DC, for Plaintiff.

A. J. Kramer, Gregory Lawrence Poe, Federal Public Defender for D.C., Washington, DC, for Defendant.

MEMORANDUM OPINION & ORDER

SULLIVAN, District Judge.

INTRODUCTION

This case is on remand from the United States Court of Appeals for the District of Columbia Circuit. The government advances two justifications for treating defendant, Russell Eugene Weston, Jr., involuntarily with antipsychotic medication. First, the government maintains that such treatment is medically appropriate and essential to render Weston non-dangerous based on medical/safety concerns, considering less intrusive means. Second, the government contends that this treatment is medically appropriate and essential to restore Weston's competency to stand trial because it cannot obtain an adjudication of his guilt or innocence using less intrusive means. Weston's attorneys' contend that the treatment is not medically appropriate because it will not restore Weston's competency and is unethical, that Weston is not dangerous, and that his trial rights will be unduly prejudiced, if medicated. Upon consideration of the government's justifications, the opposition thereto, the potential impact of antipsychotic medication on Weston's trial rights, relevant statutory and case law, the record of proceedings, evidence, and arguments of counsel at the numerous judicial oversight/evidentiary hearings, the Court authorizes the Bureau of Prisons ("BOP") to treat Weston involuntarily with antipsychotic medication.

BACKGROUND

Weston is charged in a six-count federal indictment with the premeditated murders of United States Capitol Police Officers Jacob J. Chestnut and John M. Gibson, while they were engaged in their official duties as federal law enforcement officers; one count of attempted murder of United States Capitol Police Officer Douglas B. McMillan, while he was engaged in his official duties as a federal law enforcement officer; one count of carrying and using a firearm during and in relation to a crime of violence; and two counts of carrying and using a firearm during and in relation to a crime of violence and causing a death thereby. Although the Court will not repeat the extensive procedural history of this case, a detailed account of which is found in *United States v. Weston*, 69 F.Supp.2d 99 (D.D.C.1999), the key facts are as follows.

On October 15, 1998, after a joint request by the government and Weston's attorneys, the Court appointed Dr. Sally C. Johnson,¹ pursuant to 18 U.S.C. § 4241(b), to conduct an inpatient psychiatric examination of Weston to assist the Court in determining Weston's competency to stand trial. Dr. Johnson examined Weston and concluded that he was not competent to stand trial. On April 22, 1999, the Court found Weston not competent to proceed to trial, pursuant to 18 U.S.C. § 4241(d). The Court committed Weston to the custody of the Attorney General for hospitalization and treatment to determine whether a substantial probability existed that he would attain the ca-

capacity to permit the trial to proceed in the foreseeable future. At Weston's attorneys' request, the Court stayed any action by the BOP to medicate him without his consent and ordered the BOP to provide his attorneys with notice of any administrative hearing.

Weston was admitted to Federal Correctional Institute at Butner ("FCI-Butner") on May 5, 1999. On May 20, 1999, Dr. Johnson, his treating psychiatrist, requested a court order to treat Weston with antipsychotic medication. According to Dr. Johnson, Weston refused to consent to the proposed treatment, triggering an administrative hearing. *See* 28 C.F.R. § 549.43 *et seq.* The hearing officer determined that Weston could be treated involuntarily with antipsychotic medication for the following reasons: (1) he suffers from a mental disorder; (2) he is dangerous to himself and others; (3) he is gravely disabled; (4) he is unable to function in the open mental health population; (5) he needs to be rendered competent for trial; (6) he is mentally ill; and (7) medication is necessary to treat his mental illness. Weston appealed the hearing officer's decision, and the Warden affirmed.

After the first administrative hearing, the Court exercised its judicial oversight responsibility and conducted a judicial hearing, on May 28, 1999, to review the decision to medicate Weston. The Court remanded the decision to the BOP for further proceedings due to the Court's concerns that the BOP had not precisely followed the Court's April 22, 1999 Order and fully complied with the procedures for

1. Dr. Johnson was qualified as an expert in the field of forensic psychiatry, and more particularly, in the area of the treatment and restoration of patients with paranoid schizophrenia with delusions. Dr. Johnson is a psychiatrist and Captain in the United States Public Health Service where she has been employed for approximately twenty-one years.

She is the Associate Warden for Mental Services at Federal Correctional Institute at Butner where she has worked for twenty-one years. Dr. Johnson holds teaching positions at the School of Law and the Medical Center at Duke University and also at the University of North Carolina. She is board certified in psychiatry and forensic psychiatry.

the administrative hearing. *See United States v. Weston*, 55 F.Supp.2d 23 (D.D.C. 1999).

On remand, a staff representative presented evidence to support Weston's position. He advanced arguments provided to him by Weston's attorneys and presented a report by Weston's expert witness, Raquel E. Gur, MD., Ph.D., Professor and Director of Neuropsychiatry at the University of Pennsylvania. After the second hearing, the hearing officer again determined that Weston could be medicated involuntarily for the identical reasons articulated at the first hearing. Weston again appealed the hearing officer's decision, and the Warden again affirmed.

On August 20, 1999, the Court held a second judicial oversight/evidentiary hearing to review the second decision to medicate Weston. Dr. Johnson testified and,

pursuant to Weston's attorneys' request, the Court admitted Dr. Gur's written comments into the evidentiary record. The Court upheld the BOP's decision to medicate Weston. *See Weston*, 69 F.Supp.2d at 118.

Weston appealed the decision and the D.C. Circuit remanded the case for further consideration. *See United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000) (per curiam). Accordingly, the Court conducted a four-day hearing in July 2000, during which the government advanced two justifications for medicating Weston: (1) to render him non-dangerous and (2) to render him competent for trial. Dr. Johnson and the following additional government expert witnesses in forensic psychiatry, forensic psychology, and medical ethics testified: Dr. Deborah DePrato,² Dr. Howard Zonana,³ and Dr. Edward Landis.⁴ The defense presented Professor Maxwell

2. Dr. DePrato was qualified as an expert in the field of forensic psychiatry. Dr. DePrato is an Assistant Professor of Psychiatry and Public Health, and Medical Ethics at the Louisiana State University. She is board certified in adult psychiatry and forensic psychiatry and board eligible in child psychiatry. She is the administrator for the Louisiana 24th Judicial Court Clinic where approximately 250 competency to stand trial examinations are conducted each year. She personally conducts or supervises at least 200 cases a year. Dr. DePrato is a member of the Ethics Committee for the American Academy of Psychiatry and the Law at the national level and has also been appointed as a member of the Ethics Committee Louisiana Psychiatric Medical Association.

3. Dr. Zonana was qualified as an expert in the fields of forensic psychiatry and medical ethics. Dr. Zonana is a Professor of Psychiatry at Yale University School of Medicine and an Adjunct Clinical Professor at Yale Law School. He has been teaching at Yale University School of Medicine since 1968 and at Yale Law School since 1982. Dr. Zonana is a member of the Council on Psychiatry and Law and also is a member of the Commission

on Judicial Action of the American Psychiatric Association. He is an original member of the American Academy of Psychiatry and Law and participated in establishing the ethical guidelines generated by that organization. He currently heads a forensic psychiatry program at Yale Medical School and previously was the medical director for the entire mental health center.

4. Dr. Landis was qualified as an expert in the field of forensic psychology. Dr. Landis is currently the Director of Psychology Training at FCI-Butner. He has worked at FCI-Butner since 1986 in a number of capacities. Dr. Landis is a licensed psychologist. He received his Master's Degree and Ph.D. from the University of Louisville and completed an internship jointly sponsored by the University of North Carolina School of Medicine and the Bureau of Prisons. He is a member of the American Psychological Association and is a Fellow of the American Academy of Forensic Psychology. He has a diploma in forensic psychology from the American Board of Professional Psychology. Dr. Landis is also an Assistant Professor of Psychiatry and Psychology at the University of North Carolina School of Medicine.

Gregg Bloche.⁵ Fact witnesses, including those with day-to-day treatment responsibility for Weston, also testified.

For the following reasons, the Court determined that it was in Weston's best interest to appoint an independent mental health expert, pursuant to Fed.R.Evid. 706. First, several witnesses testified regarding a potential ethical conflict arising from Dr. Johnson's three roles in this case as the forensic evaluator on the issue of competency, an expert witness for the government, and Weston's treating psychiatrist. They opined that the treating and forensic roles should be kept separate.⁶ See Hearing Transcript ("Tr.") 7/25/00

P.M. at 67–69; 7/26/00 P.M. Tr. at 29–34, 67, 70. Second, Weston's attorneys maintained that a conflict of interest could occur because Weston's medical and legal interests may conflict. Accordingly, they requested the Court to appoint a separate individual to represent Weston's medical interests.⁷ Finally, the Court had concerns about Weston's competency to make medical decisions.

The Court appointed Dr. David Daniel,⁸ "for the purpose of providing the Court with an expert opinion as to whether it is in the defendant's medical interests to administer antipsychotic medication without

5. Professor Bloche was qualified as an expert in the field of medical ethics. Professor Bloche is a Professor of Legal Ethics at Georgetown University Law Center and an Adjunct Professor of Public Health at John Hopkins University. Professor Bloche graduated from both the law and medical schools at Yale University. He treated hundreds of paranoid schizophrenic patients from 1984 to 1989 while practicing as a licensed medical doctor. He is not currently licensed to practice law or medicine and he has not practiced medicine since 1989. Professor Bloche is a policy consultant to organizations, including the National Institute of Health and the World Health Organization.

6. The potential conflict surrounding Dr. Johnson's dual role as Weston's forensic evaluator and treating psychiatrist has not yet developed, since, to date, no treatment relationship has arisen between Weston and any psychiatrist. Such a conflict can be prevented by bifurcating the roles of evaluator and treating psychiatrist.

7. Specifically, after Dr. Johnson informed the Court that she no longer considered Weston competent to make medical decisions, Weston's attorneys renewed their request for the Court to appoint a guardian *ad litem* to represent his medical interests. The parties pointed to no authority in federal criminal jurisprudence for the appointment of a guardian *ad litem* under the circumstances presented; therefore, the Court denied Weston's attorneys' request for a guardian *ad litem*.

8. Dr. Daniel graduated Phi Beta Kappa Magna Cum Laude in political science from Emory University. He attained his medical school and psychiatric residency training at Vanderbilt University where he served as chief resident. He is a diplomat of the National Board of Psychiatry and Neurology. He completed five years of advanced training in schizophrenia and psychopharmacology research within the intramural research program of the National Institute of Mental Health (NIMH). He served two years as the Medical Director of NIMH Neuropsychiatric Research Hospital. He was the founder and president of Washington Clinical Research Center (WCRC), a national leader in the conduct of inpatient clinical trials in schizophrenia. Dr. Daniel has been granted patent protection for psychopharmacological treatment advances developed at WCRC. After WCRC was acquired by Clinical Studies, Ltd., a leading multi-center clinical trials company, Dr. Daniel served as Vice President of Medical and Scientific Development at the corporate level, as well as Senior Director of all activities in the Washington, D.C. area. He has published numerous scientific papers addressing the pathophysiology and treatment of schizophrenia and has contributed to textbooks, such as the Comprehensive Textbook of Psychiatry and the Textbook of Neuropsychiatry. He is a Clinical Professor of Psychiatry and Behavioral Science at George Washington University.

his consent.”⁹ *United States v. Weston*, No. 98-357, August 23, 2000 Order (D.D.C.). On November 6, 2000, Dr. Daniel filed a comprehensive report with the Court and served it on the parties. On November 15, 2000, the Court held another evidentiary hearing at which the parties and the Court extensively examined Dr. Daniel. The Court admitted Dr. Daniel’s report into evidence, and it is incorporated in this Opinion as if set forth *seriatim*.

DISCUSSION

[1] Weston possesses a significant liberty interest in avoiding unwanted antipsychotic medication protected by the substantive component of the Due Process Clause of the Fifth Amendment. *See Riggins v. Nevada*, 504 U.S. 127, 134, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992); *Washington v. Harper*, 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). In *Harper*, the Supreme Court held that a convicted inmate “possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs.” *Harper*, 494 U.S. at 221, 110 S.Ct. 1028 (citing *Vitek v. Jones*, 445 U.S. 480, 491-94, 100 S.Ct. 1254, 63 L.Ed.2d 552 (1980); *Youngberg v. Romeo*, 457 U.S. 307, 316, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982); *Parham v. J.R.*, 442 U.S. 584, 600-01, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979)).¹⁰ A pretrial

detainee’s liberty interests are at least equal to that of a convicted prisoner. *See Riggins*, 504 U.S. at 135, 112 S.Ct. 1810; *Bell v. Wolfish*, 441 U.S. 520, 545, 99 S.Ct. 1861, 60 L.Ed.2d 447 (1979).

In *Riggins*, the Supreme Court stated:

Although we have not had occasion to develop substantive standards for judging forced administration of such drugs in the trial or pretrial settings, Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of Riggins’ own safety or the safety of others. Similarly, the State might have been able to justify medically appropriate, involuntary treatment with the drug by establishing that it could not obtain an adjudication of Riggins’ guilt or innocence by using less intrusive means.

Riggins, 504 U.S. at 135, 112 S.Ct. 1810 (internal citations omitted).

[2] The D.C. Circuit did not prescribe a substantive standard for this Court’s review “preferring instead to await the [Court’s] findings on remand using the guidance that *Riggins* provides.” *Weston*, 206 F.3d at 12-13.¹¹ Accordingly, the

9. Although the Court afforded counsel an opportunity to agree on a candidate for appointment by the Court, they were unable to do so. Thereafter, the Court undertook its own search for a qualified expert and entertained objections by counsel to a number of mental health experts.

10. *Harper* involved a convicted inmate who refused to take antipsychotic medication. The Supreme Court held that the government may deprive a convicted inmate of his fundamental liberty interest in avoiding involuntary medication, so long as the deprivation is “reasonably related to legitimate penological in-

terests.” *Harper*, 494 U.S. at 223, 110 S.Ct. 1028 (internal citations omitted).

11. Courts have applied different standards to review the decision to medicate dangerous and non-dangerous defendants. In *United States v. Charters*, 863 F.2d 302, 308 (4th Cir.1988), a pre-*Riggins* decision, the Fourth Circuit held that judicial review of a doctor’s decision to forcibly medicate a pretrial detainee to prevent dangerousness and restore competency for trial was only available to guard against arbitrariness. Likewise, in *United States v. Morgan*, No. 98-00428, February 9, 1999 Order (D.S.C.) *rev’d on other grounds*, 193 F.3d 252 (1999), the District Court of

Court applied the *Riggins* guidance to address both of the government's justifications for treating Weston involuntarily with antipsychotic medication. The government bears the burden of proof on these issues by clear and convincing evidence.¹² See *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810 (citing *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979)); *Brandon*, 158 F.3d at 960.

[3] On remand, the government contends that the Court should allow it to treat Weston involuntarily with antipsychotic medication because it is medically appropriate and necessary to attain two essential government interests: to render him non-dangerous for medical/safety concerns and to render him competent to stand trial. Therefore, the Court first analyzed whether antipsychotic treatment is medically appropriate, including whether treatment violates medical ethics. The Court concludes treatment with antipsychotic medication is medically appropriate to treat Weston's illness. Second, the Court analyzed each interest the govern-

ment advances: treating Weston's dangerousness and making him competent for trial. The Court concludes that each interest is compelling and either will support the proposed treatment, in light of less intrusive alternatives. Third, the Court analyzed the potential impact of involuntary medication on Weston's fair trial rights. At this stage of the proceedings, the Court concludes that while involuntary medication may impact these rights if Weston is tried, they will not be so affected as to prevent him from receiving a fair trial.

I. *The Proposed Treatment is Medically Appropriate*

Weston is a diagnosed paranoid schizophrenic. The parties do not dispute that treatment with antipsychotic medication is the only therapeutic intervention that may address Weston's symptoms, lessen his delusions, and make him competent to stand trial. They do dispute whether antipsychotic medication is medically appropriate

South Carolina applied an arbitrary and capricious standard of review to a doctor's decision to forcibly medicate a pretrial detainee to prevent dangerousness and restore competency for trial. See also *United States v. Keeven*, 115 F.Supp.2d 1132, 1137 (E.D.Mo.2000) (reviewing a decision to forcibly medicate a pretrial detainee on dangerousness grounds for arbitrariness).

In *United States v. Brandon*, 158 F.3d 947 (6th Cir.1998), the Sixth Circuit addressed the question of whether a non-dangerous pretrial detainee could be forcibly medicated to restore competency for trial. The *Brandon* Court held that the issue "relates solely to trial administration rather than to prison administration. To forcibly medicate Brandon, therefore, the government must satisfy strict-scrutiny review and demonstrate that its proposed approach is narrowly tailored to a compelling interest." *Id.* at 957. *Brandon* is distinguishable from *Charters*, *Morgan*, and *Keeven* because Brandon was not found to be dangerous to himself or others. See also *Bee*

v. Greaves, 744 F.2d 1387 (10th Cir.1984) (adopting strict-scrutiny review to determine whether a pretrial detainee may be forcibly medicated to render him competent to stand trial). However, the court in *United States v. Sanchez-Hurtado*, 90 F.Supp.2d 1049, 1055 (S.D.Ca.1999), concluded that the strict-scrutiny review in *Brandon* is "contrary to the majority opinion in *Riggins*." The court indicated that *Riggins* should guide a determination as to whether the government can involuntarily medicate a pretrial detainee to make him competent to stand trial. See *id.*; see also *State v. Baker*, 245 Neb. 153, 511 N.W.2d 757 (1994) (holding that a pretrial detainee charged with first-degree murder could be medicated, in part, because he was dangerous).

12. The parties concur with this standard; however, the government indicates that in subsequent appellate proceedings it intends to advocate a reasonableness standard of review; thus, the government argues that its position here should not be construed as a waiver.

given a range of considerations, including its likely side effects and medical ethics implications.

A. Treatment for Weston's Condition

Antipsychotic medication is the medically acceptable and indicated treatment for Weston's illness. *See* Tr. at 11 (Dr. Johnson); Dr. Daniel's Report at 38; 7/25/00 P.M. Tr. at 10–11 (Dr. DePrato); 7/26/00 P.M. Tr. at 67–68 (Dr. Zonana). While Weston's attorneys do not propose any alternative treatments for Weston's symptoms, they dispute the efficacy of antipsychotic medication. Weston's expert, Dr. Gur, opined that "within a reasonable degree of medical certainty, . . . antipsychotic medication will not restore Mr. Weston's competency." Dr. Gur Ltr. at ¶ 4. Dr. Gur explained the basis for her opinion:

In light of the length of time (about two decades) that he has experienced delusions, the pervasiveness of his delusional system, lack of treatment, and the unfortunate fact that he has acted on his delusions, make it extremely unlikely that medication will eliminate or substantially attenuate his delusions. There is a growing body of evidence that suggest[s] that when the psychotic process remains untreated it causes further deterioration in brain function resembling an irreversible toxic effect.

Id. at ¶ 4.

Dr. Johnson opines that Weston's delusions do not reach back twenty years, at

least not in their current form. Rather, "it's only been in the later years, particularly from 1996 to present, that we have seen this full-blown delusional system." 7/8/99 Tr. at 58–59. She testified that the chance Weston will respond positively to the treatment is enhanced because he has had relatively little exposure to antipsychotic medication. *See* 8/20/99 Tr. at 56. Weston already exhibited a receptiveness to treatment with antipsychotic medication in 1996 in Montana. *See* 7/27/00 A.M. Tr. at 121.¹³ Specifically, Weston was "calmer, less agitated, less threatening, exhibited some insight that he was ill, less emotionally invested in his delusional material and better able to attend to other matters after treatment." Dr. Daniel's Report at 40. Moreover, approximately seventy to eighty percent of schizophrenics respond positively to medication. *See* 7/24/00 P.M. Tr. at 108.

Dr. Daniel concurs that Weston is likely to benefit from treatment with antipsychotic medication. *See* Dr. Daniel's Report at 34. He notes that nearly all patients with acute psychotic symptoms benefit from antipsychotic medication. *See id.* at 35. Dr. Daniel also opines that Weston will respond favorably to medication, based on his response to treatment in 1996, noting that "[c]linicians generally regard past treatment response as a valuable predictor of future treatment response." *Id.* at 40.

The Court credits Dr. Daniel and the government experts and concludes that an-

13. The Montana State Hospital, Warm Springs, Montana, medical records provide insight into the effectiveness of treating Weston with antipsychotic medication. Weston's Discharge Summary, signed by three hospital staff members, including one psychiatrist, states: "Russell does notice improvement on his medications. He is aware that his thoughts are more organized and his energy level is less erratic. . . . He does have some persistent delusional beliefs but has more in-

sight when medicated and would not become violent and act upon his fears." In addition, the Montana State Hospital Aftercare Plan, signed by a physician, states "Russell remains delusional; however, he appears less compelled to share his belief with others, and when he does, it is with much less emotion and intensity than upon admission. He is currently pleasant and cooperative, and has made no threats toward anyone since he has been stabilized on medications."

tipsychotic medication is the medically appropriate treatment for Weston's condition.

B. Side Effects of Antipsychotic Medication

The Court must balance the potential efficacy of antipsychotic medication against the likelihood and severity of its potential side effects, which are relevant to Weston's medical interests and trial rights. Here, the Court will focus on Weston's medical interests. The Court will scrutinize the fair trial implications in that section of this Opinion.

The likelihood and severity of possible side effects depend on the type of antipsychotic medication administered. Generally, there are two categories of antipsychotics: (1) typicals, the older generation of antipsychotics, and (2) atypicals, the newer antipsychotics with lower side effect profiles. Currently, atypical antipsychotic medications are not available in injectable form. *See* 7/24/00 P.M. Tr. at 64–66. Dr. Johnson has stated that she would not attempt to treat Weston with atypical antipsychotics, but would start with Haldol, an injectable typical with which the side effect tardive dyskinesia is closely associated. *See id.* at 64–65, 92–94. Dr. Johnson's clinical experience suggests that following the short-term use of an injectable typical antipsychotic on an involuntary basis, the patient generally begins to respond and, ultimately, agrees to take orally atypical medications. *See* 7/24/00 A.M. Tr. at 107. Since Weston may be treated with both types of antipsychotic medication, the Court will analyze the side effects of both.

1. Typical Antipsychotics

Typical antipsychotics can produce the following side effects: (1) dystonic or acute

dystonic reactions, which involve a stiffening of muscles; (2) acuesthesia, which is restlessness or an inability to sit still; (3) Parkinsonian side effects, which can slow an individual; (4) tardive dyskinesia, which causes repetitive, involuntary tic-like movements of the face, eyelids, and mouth; (5) neuroleptic malignant syndrome ("NMS"), which causes temperature control problems and stiffness; and (6) perioral tremor, referred to as rabbit syndrome because of the mouth movements associated with it. *See* 7/24/00 A.M. Tr. at 109–11; 7/24/00 P.M. Tr. at 6, 101.¹⁴

The government's witnesses testified that each of these potential side effects is generally manageable and outweighed by the potential benefits of medication. *See* 5/28/99 A.M. Tr. at 19–20; 7/24/00 A.M. Tr. at 105–12 (Dr. Johnson); 7/24/00 P.M. Tr. at 112 (Dr. Johnson); 7/25/00 A.M. Tr. at 40 (Dr. Johnson); 7/25/00 P.M. Tr. at 10–11 (Dr. DePrato). The defense presented little expert testimony regarding side effects, but presented a more negative picture of medication during cross examination and in their pleadings. *See generally* 7/24/00 P.M. Tr. at 91–112 (Dr. Johnson).

Weston's experience with antipsychotic medication is inconclusive. During his commitment in Montana, Weston received antipsychotic medication for about two months during which time he reportedly experienced some improvement and also appeared to suffer some side effects. Weston apparently suffered from restlessness, or acuesthesia, and stiffness, a dystonic reaction. *See* 7/24/00 P.M. Tr. at 5. Nevertheless, Dr. Johnson testified that acuesthesia can be treated with side effect medication, by adjusting the dose of medi-

¹⁴ Dr. Daniel notes the following potential side effects: 1) motor side effects; 2) cardiovascular side effects; 3) sedation; 4) weight

gain; 5) neuroleptic malignant syndrome; 6) hematologic disorders; 7) endocrine disorders; and 8) seizures.

cation, or by changing the type of medication. *See* 7/24/00 P.M. Tr. at 7. In addition, Dr. Johnson stated that while, in its most acute and rare form, an acute dystonic reaction can be fatal, any acute dystonic reactions can quickly be treated using a side-effect medication, and that in her experience, such treatment is almost one hundred percent successful. *See* 7/24/00 P.M. Tr. at 95–97.

The experts also discussed the other possible side effects from typical antipsychotic medication. Parkinsonian side effects can be effectively treated by decreasing the dose or by a variety of other adjunctive medications. *See* 7/24/00 A.M. Tr. at 110–11; 7/24/00 P.M. Tr. at 99. Dr. Johnson testified that tardive dyskinesia and perioral tremor generally occur only after a patient has been treated with high doses of medication over an extended period. *See* 7/24/00 A.M. Tr. at 111; 7/24/00 P.M. Tr. at 101. NMS resembles a severe form of Parkinsonianism with catatonia that develops as an idiosyncratic response. *See* 7/24/00 A.M. Tr. at 111. Without immediate medical attention, ten percent of persons die when NMS develops. *See* 7/24/00 P.M. Tr. at 99. However, Dr. Johnson testified that, should either NMS or tardive dyskinesia develop, the type of medication can be switched or the medication can be stopped. *See* 7/24/00 A.M. Tr. at 111.

2. Atypical Antipsychotics

Atypical antipsychotics have a more favorable side effect profile and are better tolerated by the average patient. *See* 7/24/00 P.M. Tr. at 3; 7/24/00 A.M. Tr. at 108. Dr. Zonana testified that atypicals have so few side effects that studies use them on individuals who have not yet been diagnosed with schizophrenia, but who only have symptoms that suggest they might develop the disease. *See* 7/26/00

A.M. Tr. at 39. In short, “there is a world of difference” between the antipsychotic medications described in the judicial opinions of the early 1990s and the current atypical antipsychotic medications now available. 7/26/00 P.M. Tr. at 95 (Dr. Johnson). Despite Dr. Gur’s opinion that medication would not be effective, she stated that if Weston were medicated, he should be given atypical antipsychotic medications because they “have better side effect profiles, are better tolerated and are effective on a broader range of symptoms.” Dr. Gur Ltr. at ¶ 5.

Dr. Johnson acknowledged that serious side effects may occur with the atypical medications. Agranulocytosis is a severe side effect, associated with clozapine, that may result in death. *See* 7/24/00 P.M. Tr. at 3–4. However, there is a highly effective monitoring system to prevent this result, if clozapine is administered. *See id.* In addition, atypical medications may cause sedation, weight gain, seizures, and problems with lipid metabolism. However, Dr. Johnson stated that, as with the typical antipsychotics, any treatment regimen involving atypical antipsychotics can be carefully monitored so as to “identify a patient who is heading into a problem area and stop the medication or make an adjustment.” 7/24/00 P.M. Tr. at 4; *see also* 7/26/00 A.M. Tr. at 61 (Dr. Zonana). Additionally, Dr. Daniel notes that while serious side effects are associated with antipsychotic medications, “the side effects can most often be managed by an alternative course of treatment provided to the benefit of the patient. General experience with antipsychotics, particularly the newer medications, indicates that given their benefits they are reasonably safe and well tolerated.” Dr. Daniel’s Report at 37.

The Court acknowledges that there is a limited understanding of the side effects of atypical antipsychotics. Weston presented

evidence from Professor Bloche, who did not assess the specifics of antipsychotics, just the implications of their status as a relatively new medical technology.¹⁵ See 7/26/00 P.M. Tr. at 37.

3. Analysis

The potential side effects of antipsychotic medication are a cause for concern since the atypicals are relatively new and there is little data about their long-term effects and the typicals have many side effects. Nevertheless, the Court must weigh these concerns against the overwhelming evidence that antipsychotic medication is the cornerstone of treating Weston's illness. Dr. Zonana stated that the standard treatment for schizophrenia is antipsychotic medication, and not to treat Weston with such medication would be medically negligent. See 7/26/00 A.M. Tr. at 64; see also 7/24/00 P.M. Tr. at 11 (Dr. Johnson). Moreover, Drs. Zonana and DePrato testified that they were unaware of any hospital in the country that would not treat Weston with antipsychotic medication. 7/25/00 P.M. Tr. at 11 (Dr. DePrato); 7/25/00 P.M. Tr. at 54–55 (Dr. Zonana).

Certainly, risks and uncertainties are associated with antipsychotic medication. However, the powerful testimony of Dr. Daniel and the government experts persuade the Court that antipsychotic medication is appropriate, notwithstanding the potential side effects since they can be managed with close oversight.

15. Professor Bloche testified that new kinds of medical technology, such as antipsychotic drugs, enter the market accompanied by promising reports and become more commonplace in clinical practice. Typically, he stated it is realized only years later—sometimes decades later—that the technology is not as effective as originally anticipated and may have side effects that were not originally appreciated. See 7/26/00 P.M. Tr. at 37–39. But see 5/28/99 A.M. Tr. at 19–20. However,

C. Medical Ethics

Weston's attorneys raise two ethical objections to the proposed treatment. First, they claim that involuntary treatment with antipsychotic medication is not medically appropriate because treating a pre-trial detainee solely to make him competent to stand trial is unethical. Second, they contend that, even if a pretrial detainee may be involuntarily medicated, a treating psychiatrist must take into account the context of the detainee's circumstances in determining what is medically appropriate and that this treatment is unethical in a potential capital case.

1. A Psychiatrist Can Treat Solely to Render a Defendant Competent to Stand Trial

[4] The first ethical argument posits that a doctor cannot ethically treat a defendant solely to make him competent to stand trial, since such action would make the psychiatrist an agent of the government rather than the patient. The Court is unaware of any legal authority to support this theory. The defense relies on the testimony of Professor Bloche, who relied on the United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, U.N.G.A. Res., New York, December 18, 1982, U.N. Doc. A/REX/37/94 ("1982 U.N. Principles"),¹⁶ and the

he has not studied antipsychotic medications, has not written about antipsychotic medication, has not previously testified as an expert, and claims no "specific and detailed knowledge about the controversy over typical versus atypical antipsychotics." 7/26/00 P.M. Tr. at 14, 17–18, 19.

16. The 1982 U.N. Principles were validly promulgated and adopted and have the status of customary international law.

Hippocratic Oath. *See* 7/26/00 P.M. Tr. at 29–30, 31–33. Professor Bloche asserts that these ethical norms govern a psychiatrist's participation in the medication of a pretrial detainee. This argument assumes that no other basis, such as dangerousness, motivates the government's effort to medicate Weston.

The Court is not persuaded that the 1982 U.N. Principles, as interpreted by Professor Bloche, mandate a finding that it would be unethical for a psychiatrist to medicate a pretrial detainee involuntarily to restore competency. The 1982 U.N. Principles state that “[i]t is a contravention of medical ethics for health personnel, particularly psychiatrists, to be involved in any professional relationships with prisoners or detainees the purpose of which is not solely to evaluate, protect, or improve their physical and mental health.” 1982 U.N. Principles, U.N. Doc. A/REX/37/94 (Principle 3). Those principles were available to the U.S. medical community when it established its ethical guidelines, which neither sanction nor prohibit involuntary medication for a pretrial detainee. The more recent guidelines and debates among the American Medical Association and other U.S. medical ethical societies have not embraced the argument advanced by the defense. The Court will not create medical ethical prohibitions where the medical community has not imposed such prohibitions. Similarly, the Court does not credit Professor Bloche's interpretation of the Hippocratic Oath, which states, in part, that “into each house I come I will enter only for the good of my patients,” over that of numerous licensed medical psychiatrists who testified that medical ethics do not preclude medicating Weston. *See* 7/25/00 P.M. Tr. at 13–14 (Dr. DePrato); 7/25/00 P.M. Tr. at 72 (Dr. Zonana); 7/24/00 P.M. Tr. at 13–14 (Dr. Johnson).

Thus, while the Court concludes that an individual psychiatrist might object to involuntarily treating Weston with medication due to the psychiatrist's own sense of ethics, no established ethical barrier to such treatment exists.

2. *Involuntary Treatment Could Result in the Death Penalty*

The defense maintains that involuntary treatment with medication would be unethical and medically inappropriate in this case because it could potentially begin an unbroken chain of events leading to Weston's execution. This argument assumes Weston will be rendered competent, the government will seek the death penalty, Weston will be convicted and sentenced to death, and will remain competent for trial and execution even if he is later permitted to refuse medication. The defense contends that the treating psychiatrist must assume that permanent remission is possible or, in the alternative, that Weston would continue to be medicated during any post-conviction legal proceedings, and executed. However, Weston's witness, Professor Bloche, conceded that the link between pretrial treatment and execution is “attenuat[ed].” 7/26/00 P.M. Tr. at 55–56.

Nevertheless, the Court is persuaded by the opinions of Drs. Zonana and DePrato, both of whom currently hold positions on medical ethics panels, that medical ethics does not preclude medicating a patient in Weston's situation. *See* 7/25/00 P.M. Tr. at 71–72 (Dr. Zonana); 7/25/00 P.M. Tr. at 13–14 (Dr. DePrato). The controlling medical ethics authorities in this area, codified by the American Medical Association and its Council on Ethical and Judicial Affairs, do not bar treatment of a patient such as Weston. *See* 7/25/00 P.M. Tr. at 59–61. These guidelines distinguish between a convicted defendant and a pretrial detainee. They state that it is unethical to medicate a convicted defendant solely to

render him competent to be executed. *See* 7/25/00 P.M. Tr. at 60 (Dr. Zonana). These guidelines do not extend the same prohibition to a pretrial detainee, even in a potential capital case. *See* 7/25/00 P.M. Tr. at 73 (Dr. Zonana).

Furthermore, the Court rejects the assumption that once medicated Weston will be executed. Safeguards exist at all stages of the proceedings to prevent the unbroken chain from involuntary treatment to execution hypothesized by Weston's attorneys. The Court will be vigilant and available to address whether Weston should be permitted to refuse medication at a later stage of the proceedings. Moreover, the Court is satisfied that no presumption exists that pre-trial involuntary medication will automatically continue post-trial because Weston will be reassessed if his competency is restored. *See* 7/26/00 P.M. Tr. at 87–89 (Dr. Johnson).

D. Conclusion

The Court holds that antipsychotic medication is the only therapeutic, medically appropriate treatment for Weston's illness, notwithstanding its potential side effects. Further, the Court holds that no established ethical barriers render such treatment medically inappropriate for Weston at this time.

II. The Government's Interest in Medicating Weston

The Court holds that there are two essential government interests, either of

which support medicating Weston: (1) to render him non-dangerous and (2) to render him competent to stand trial.

A. Dangerousness: The Proposed Treatment is Essential for the Safety of Others

The D.C. Circuit held that “[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing, so as to render him dangerous.” *Weston*, 206 F.3d at 14. The government presented additional evidence and testimony from the following witnesses: (1) Dr. Johnson, Weston's treating psychiatrist and an expert witness; (2) Dr. Landis, Weston's treating psychologist and an expert witness; (3) Drs. DePrato and Zonana, expert witnesses; and (4) Commander Penny Royall, Weston's physical therapist. In addition, Dr. Daniel testified as a Court appointed independent expert. The Court reviewed the original evidence of dangerousness coupled with the new evidence presented. In view of the expanded evidentiary record and the testimony of the medical experts, the Court rejects Weston's attorneys' arguments and holds that the government has proven, by at least clear and convincing evidence, that Weston presents a risk of danger to others.¹⁷

In 1999, Dr. Johnson testified that Weston was dangerous because he acted on his

¹⁷ The government has not presented evidence sufficient for the Court to find that Weston's condition has changed to make him more of a danger to himself now than at the time of the Court's September 9, 1999 Opinion. The Court recognizes that Weston is a danger to others, but not necessarily a danger to himself. The government argues that Weston is a danger to himself because, in his current, non-responsive, delusional state, he neither consistently nor fully cooperates with his own physical treatment plan. In fact, Dr.

Daniel states that Weston's illness has progressed to the point where Weston is preoccupied and dominated by his delusional system “to the exclusion of almost all aspects to existence beyond vegetative functions.” Dr. Daniel's Report at 39. While this is of concern, the Court is unaware of authority suggesting that this sort of passive deterioration supports a finding of dangerousness to one's self.

delusions in the past. *See* 7/8/99 Tr. at 51. She also testified that Weston's delusions caused him to place himself in a high-risk situation where the risk of serious injury was great and ultimately realized. *See id.* at 51. Dr. Johnson now states that Weston's delusions have expanded since September 1999. *See* 7/24/00 A.M. Tr. at 92–93. Moreover, she testified that because he incorporates those around him into his delusions, they are at risk of harm. *See id.* at 99.

The government presented persuasive evidence that Weston's deterioration, since this Court's September 9, 1999 Opinion, has resulted in instances of hostility. Weston has not presented any evidence that rebuts the conclusion that his condition has deteriorated. Accordingly, the Court concludes that his condition has further deteriorated since the September 9, 1999 Opinion and that Weston is indeed a danger to others.

Several professionals charged with Weston's care have experienced instances of hostility since the Court's September 9, 1999, Opinion. Commander Royall, Weston's physical therapist, testified that in October 1999, Weston "said something to the effect that, I am Commander of all the armies of the world and you will no longer be able to touch me" when she tried to work with him. 7/24/00 A.M. Tr. at 13. A hostile stare accompanied this comment and caused her to feel frightened and threatened. *See id.* at 20, 37, 42. Commander Royall stated that, in her seven years at FCI–Butner, this was one of the very few times that she had ever felt threatened by a patient. *See id.*

Dr. Johnson also testified that there is an ongoing risk that Weston will commit suicide in his present untreated state. 7/24/00 A.M. Tr. at 99; *see also* 7/25/00 A.M. Tr. at 38 (13% incidence of successful suicides in patients with Weston's symptom picture). In Dr. Dan-

Dr. Landis, the forensic psychologist, stated that he perceived himself to be at risk when Weston accused him, in April 2000, of being a murderer who had killed his wife and raped his children. *See* 7/25/00 A.M. Tr. at 75–76, 90. Weston, in a very loud voice, accused Dr. Landis of murderous conduct and then began progressing toward Dr. Landis until Weston stood right in front of him. *See id.* at 75–76. Dr. Landis was concerned, "[a]s somebody who has spent a great many years with people with serious mental illnesses, this was one of a very limited number of occasions where I considered I'd better think fast." *Id.* at 90. In addition, Dr. Landis testified that an art therapist, who worked with Weston in December 1999, became frightened when Weston jerked away from her and declared that he was a Congressional Medal of Honor winner and that she was not to come within 10 feet of him. *See id.* at 78–79. Dr. Landis also testified regarding Weston's refusal to take an antiblood clot medication and his delusional statement to a nurse that if she forcibly injected him she would be prosecuted and dealt with by NATO. *See id.* at 84.

These incidents of hostility bolster Dr. Johnson's initial conclusion that Weston's delusions cause him to place himself in high-risk situations that could cause him to hurt others. Weston "has been perceived as more menacing . . . [j]ust angry and belligerent, not wanting people to come into his room." 7/24/00 A.M. Tr. at 92. Weston's delusions incorporate those who are treating him. These delusions relate to murder, rape, and war. He believes that he is the commander of the armies,

iel's opinion, this risk might be higher for Weston because of Weston's belief that death is not permanent. Dr. Daniel's Report at 41. However, this evidence is essentially the same as the evidence before the Court on September 9, 1999.

that “the people around him, the government, his attorneys, the staff, other unidentified people are doing terrible things, and that he has a mission to stop this regardless of what the consequences are.” 7/24/00 A.M. Tr. at 99. He also believes that death is not permanent. *See id.* This sort of delusional thinking is at the heart of his alleged conduct at the U.S. Capitol.

The proposed medication is not to control Weston after he has committed an act of violence; rather, it is to prevent Weston from harming others, in light of the evidence that his mental condition could cause such harm. *Cf. United States v. Horne*, 955 F.Supp. 1141, 1147 (D.Minn. 1997) (holding that “unless the respondent’s mental illness is treated, he would pose a danger to prison staff and his fellow inmates if he is removed from segregation”). As Dr. Daniel noted “[u]nmedicated and in the general population, [Weston] would be at an extremely high risk of inflicting violence on other inmates, staff members, or visitors who might become incorporated into his delusional system. The timing of such potential violence could be very hard to predict.” Dr. Daniel’s Report at 34.

It is uncontroverted that Weston has not struck or physically injured anyone while incarcerated at FCI–Butner. However, a finding of dangerousness does not require such acts. *See, e.g., United States v. Husar*, 859 F.2d 1494, 1498 (D.C.Cir.1988) (finding that the district court did not err in holding that defendant should not be released because the smashing of a glass case, which led to his arrest and confinement, sufficiently indicated his dangerousness); *United States v. Muhammad*, 165 F.3d 327, 336 (5th Cir.1999) (finding defendant dangerous because “whatever physi-

cal or medical problems she had or might have in the future would go undetected or undiagnosed” due to her “refusal to have medical treatment”), *cert. denied*, 526 U.S. 1138, 119 S.Ct. 1795, 143 L.Ed.2d 1022 (1999); *United States v. S.A.*, 129 F.3d 995, 1001 (8th Cir.1997) (defendant found dangerous despite no overt acts of violence because “[defendant] has spent most of his time at FMC–Rochester in isolation and has therefore had minimal contact with others and, consequently, minimal opportunity to engage in violent behavior”); *United States v. Ecker*, 30 F.3d 966, 970 (8th Cir.1994) (“[o]vert acts of violence, however, are not required to prove dangerousness”); *United States v. Steil*, 916 F.2d 485, 488 (8th Cir.1990) (finding appellant should be committed based on testimony from five mental health professionals that he was mentally ill and dangerous). The potential for immediate harm exists because Weston’s illness remains untreated.

Nor is Weston’s dangerousness necessarily belied by his occasional cooperation with staff members. As Dr. Johnson stated, it is the unpredictability of Weston’s actions that makes him dangerous. She indicated that often schizophrenic behavior has no warning signs; schizophrenics “could appear very calm and turn around and assault someone or kill someone.” 7/25/00 A.M. Tr. at 7. Dr. Landis also stated that “[p]eople with schizophrenia can behave erratically [C]ertainly one of the things that’s characteristic in Mr. Weston’s case is very sporadically you have these surprise incidents.” *Id.* at 104.

Numerous medical experts, including Drs. Daniel, DePrato, and Zonana, also persuade the Court that Weston is dangerous.¹⁸ Dr. Daniel’s report explains that in

18. Drs. DePrato and Zonana based their opinions on the testimony and conclusions

reached by other experts. Nevertheless, the Court concludes that their opinions, as well as

assessing dangerousness, he looks to: (1) the individual's past violent behavior; (2) the individual's underlying condition; and (3) the individual's lack of expression of regret for past violent behavior. Dr. Daniel's Report at 32–34. Weston's past violent behavior includes an October 15, 1996 assault on a staff member at Montana State Hospital, the July 24, 1998 incident at the U.S. Capitol, and the previously discussed incidents of hostility at FCI–Butner. Dr. Daniel stated that Weston's underlying condition, paranoid schizophrenia, is the etiology of the paranoid delusions that caused Weston's past acts of violence, and continue to make Weston dangerous. Dr. Daniel stated that “the delusional material the patient has expressed indicates that he believes that death for himself and others is not permanent. Thus, the consequences of suicide or homicide are substantially reduced in his belief system and the attendant risk of violence is heightened.” *Id.* at 33. Finally, Dr. Daniel stated that Weston is not documented to have expressed regret for his past violent behavior or shown insight into the delusional basis of his past violent behavior which increases the chance Weston could repeat similar acts. Dr. Daniel's Report at 34.

The Court has reviewed possible alternatives to antipsychotic medication that may be less intrusive and found them inadequate for treating and controlling Weston's dangerousness. Dr. Johnson testified that she has considered at length and rejected alternative treatment interventions, such as individual psychotherapy and group therapy, because they would not have any impact on Weston's mental ill-

ness. *See* 7/8/99 Tr. at 55–56. Dr. Johnson expressed the same opinion at the July 2000 hearing, testifying that alternatives such as verbal therapy, recreation therapy, antidepressants, anti-anxiety medication, or sedatives, were either ineffective or not indicated for Weston in his current condition. *See* 7/24/00 A.M. Tr. at 98–99.

To mitigate Weston's dangerousness, he is currently housed in FCI–Butner's Seclusion Admission Unit and is under twenty-four hour observation by a guard posted outside his room. Nevertheless, staff must enter his room to check on him and tend to his basic needs. *See* 7/25/00 A.M. Tr. at 69–70. As Dr. Landis stated, “there is no way to avoid him from having contact with the nurses, the officers on a daily basis, and with Dr. Johnson and I on a somewhat less frequent basis” 7/25/00 A.M. Tr. at 71. In Dr. Johnson's opinion, Weston “presents an immediate risk of harm to people who are entering his room.” 7/24/00 A.M. Tr. at 91. At the onset, the Court notes that Weston does not have a due process right to seclusion. *See Horne*, 955 F.Supp. at 1148–1149 (holding that “prisoners do not have a due process right to remain in isolation or segregation to avoid a particular form of treatment, such as the forcible administration of psychotropic medications”); *see also United States v. Watson*, 893 F.2d 970, 982 (8th Cir.1990) (doubting that segregated confinement constituted a less restrictive alternative to drug treatment of a prisoner.)

Seclusion is simply the warehousing of Weston in a psychotic state. *See* 7/24/00 A.M. Tr. at 100. It is not treatment;¹⁹ at

those of Drs. Johnson, Daniel, and Landis, are sound, based on sufficient education and experience, and are not outweighed by other evidence.

19. “The accrediting organizations in the country, particularly the Joint Commission for Accreditation of Health Care Facilities, [are] increasingly placing more stringent standards on the use of seclusion, because of the

best it contains dangerousness. *See* 7/24/00 A.M. Tr. at 100; 7/25/00 P.M. Tr. at 13. In fact, seclusion could be the cause of further deterioration of Weston, as indicated by the new evidence. *See* 7/24/00 A.M. Tr. at 101; 7/25/00 P.M. Tr. at 13. Dr. Daniel indicated that seclusion “has the potential to interact with and worsen core “negative” symptoms of schizophrenia, including autistic tendencies, social isolation, egocentricity, passive social withdrawal, and general social impairment.” Dr. Daniel’s Report at 38. The medical experts also stressed that seclusion is typically viewed as a short-term, last resort, rather than an acceptable long-term strategy to cope with dangerousness. *See* 7/24/00 A.M. Tr. at 59–60, 100–03; 7/25/00 A.M. Tr. at 104–05.

Further, it is Weston’s dangerousness that mandates his seclusion and twenty-four-hour observation. *See* 7/24/00 P.M. Tr. at 12 (Dr. Johnson stating that the “first issue with Mr. Weston is to get his psychotic symptoms under control and decrease his dangerousness. That is the factor that is placing the restrictions on his housing situation at this particular point in time.”). According to Dr. Daniel, Weston’s current conditions of confinement “cannot be inferred to indicate that he is not acutely dangerous, only that he is prevented from carrying out dangerous activity.” Dr. Daniel’s Report at 34. Since seclusion has no therapeutic effect, it does not address the government’s interest in treating Weston’s illness.

Also, the doctors and the BOP employees entrusted with his care and treatment clearly do not perceive seclusion as a legitimate, ongoing response to dangerousness. *See, e.g.,* 7/24/00 A.M. Tr. at 60, 100; 7/25/00 P.M. Tr. at 13, 17–18. The government presented testimony, in addition to that of the medical experts, that the ex-

treme measures taken by FCI–Butner personnel, seclusion coupled with twenty-four hour observation, are not an administratively feasible long-term solution to Weston’s present dangerousness. First, Assistant Director Phillip Steven Wise of the BOP’s Health Services testified that seclusion beds are designed only for short-term use, “to stabilize, to assess, and then put an inmate or individual back in a more normal sort of setting.” 7/24/00 A.M. Tr. at 60. Second, seclusion beds are a limited, finite resource and continuing to house Weston in seclusion is straining the BOP’s resources. *See* 7/24/00 A.M. Tr. at 62; *Harper*, 494 U.S. at 227, 110 S.Ct. 1028 (holding that respondent “failed to demonstrate that . . . seclusion [is an] acceptable substitute[] for antipsychotic drugs, in terms of either their medical effectiveness or their toll on limited prison resources”). The long-term use of seclusion beds by patients like Weston would be very troubling according to Assistant Director Wise. *See* 7/24/00 A.M. Tr. at 62. These concerns undermine the usefulness of seclusion as a means to treat dangerousness. The courts in *Watson* and *Horne* considered these factors important in determining whether to use isolation instead of drug treatment to address dangerousness. *See Watson*, 893 F.2d at 982; *Horne*, 955 F.Supp. at 1149.

In conclusion, the Court is persuaded that the government has presented additional factual evidence, as well as expert testimony, to support a conclusion that Weston is a danger to those around him. Having considered the alternatives to antipsychotic medication, the Court holds that antipsychotic medication is essential to control and treat Weston’s dangerousness to others. In view of the foregoing, the Court holds that Weston poses a danger to

negative consequences it has to an individu-

al.” 7/24/00 A.M. Tr. at 102.

others, that medication would significantly diminish his dangerousness, and that no less intrusive means exist to ensure the safety of those around him.

B. Trial Competency: The Government Cannot Obtain an Adjudication of Weston's Guilt or Innocence with Less Intrusive Means

The government has an essential interest in bringing Weston to trial. *See Illinois v. Allen*, 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring) (“[c]onstitutional power to bring an accused to trial is fundamental to a scheme of ‘ordered liberty’ and prerequisite to social justice and peace”); *Winston v. Lee*, 470 U.S. 753, 762, 105 S.Ct. 1611, 84 L.Ed.2d 662 (1985) (“the community’s interest in fairly and accurately determining guilt or innocence . . . is of course of great importance”); *Brandon*, 158 F.3d at 954 (“government’s interest in bringing a defendant to trial is substantial”); *Khiem v. United States*, 612 A.2d 160, 167 (D.C. 1992) (“government’s interest [in bringing a murder defendant to trial] is a ‘fundamental’ one and of a very high order indeed”).

It does not follow, however, that the government has an essential interest in prosecuting every alleged crime so as to justify involuntary medication in all cases. *See Brandon*, 158 F.3d at 961; *Woodland v. Angus*, 820 F.Supp. 1497, 1513 (1993) (stating that “the State’s interest is not in trying plaintiff under any circumstances, but in trying plaintiff fairly and accurately”). Nor is the Court articulating a bright line test for determining which crimes trigger an essential interest in bringing a defendant to trial. However, the Court is persuaded that the facts of this particular case give rise to such an essential interest given the serious and violent nature of the charges, that the

immediate victims were federal law enforcement officers performing their official duties, and that the killings took place inside the U.S. Capitol amid a crowd of innocent bystanders. This case is unlike *Brandon* where the defendant was charged with sending a threatening letter through the mail, a crime carrying only a five-year penalty.

Involuntary medication is the least intrusive means to meet this essential government interest because, as previously discussed, antipsychotic medication is the only therapeutic intervention available that could possibly improve Weston’s symptom picture, lessen his delusions, and make him competent to stand trial. Although, it is not certain that the medication will restore Weston’s competency, the Court credits the previously discussed testimony of the mental health experts that this outcome is likely. *See Woodland*, 820 F.Supp. at 1512 (stating that where the state seeks to medicate a pretrial detainee involuntarily to render him competent to stand trial, the state need not guarantee that the medication will achieve that purpose but “there must be at least a showing that such a course of action can reasonably be expected to in fact render the defendant competent”).

III. *Weston’s Trial Rights*

Although the government’s interests in treating Weston’s dangerousness and restoring his competency are essential and antipsychotic medication is the least intrusive means to meet these interests, the Court must still balance those interests against Weston’s trial rights. Involuntary antipsychotic medication has the potential to adversely affect Weston’s ability to obtain a fair trial. *See Weston*, 206 F.3d at 14; *Brandon*, 158 F.3d at 954. Accordingly, before allowing the government to medicate Weston, the Court must consider the

potential impact of medication on his fair trial rights.

The Court has carefully analyzed whether the government's pursuit of its interests will impair Weston's following Fifth and Sixth Amendment rights: (1) the right not to be tried unless competent to "consult with counsel and assist in his defense," *Drope v. Missouri*, 420 U.S. 162, 171, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975); (2) the right to testify and to "present his own version of events in his own words," *Rock v. Arkansas*, 483 U.S. 44, 107 S.Ct. 2704, 97 L.Ed.2d 37 (1987); (3) the right to be present in the courtroom at every stage of the trial, *see Allen*, 397 U.S. at 338, 90 S.Ct. 1057; and (4) the right to present a defense, including an insanity defense, *see* 18 U.S.C. § 17 (setting forth requirements for insanity defense).

A. Weston's Right to Consult with Counsel and Assist in his Defense

Ironically, a strong likelihood exists that medication will enhance some of Weston's trial rights, particularly his right to consult with counsel and to assist in his defense. Currently, Weston is either unable or unwilling to speak with his attorneys. *See* 7/24/00 A.M. Tr. at 87–89. The evidence suggests that he may not believe that his attorneys are actually representing him. Dr. Johnson testified that "[h]e has all along had an intermittent belief that he has other attorneys from the past, famous attorneys who are involved in his case and who continue to have an interest in his case." *Id.* at 89. Indeed, while Weston appeared somewhat attentive during the July 2000 hearing, Dr. Johnson testified that Weston was not able to follow and process what happens in court or while at FCI–Butner. *See* 7/24/00 A.M. Tr. at 89–90.

Successful treatment with antipsychotic medication will probably decrease Wes-

ton's delusional thinking and increase his attention and ability to concentrate. *See* 7/25/00 A.M. Tr. at 24. Medication, therefore, has the potential of greatly enhancing Weston's ability to communicate meaningfully with his attorneys. Medication should also enhance Weston's ability to understand and follow the testimony at trial.

B. Weston's Right to Testify

Medication might alter the content of Weston's testimony and interfere with his ability to testify. For instance, Dr. Johnson testified that antipsychotic medication might cause Weston to filter out events that might be too disturbing for him to cope with or to recount events as one would recount a dream. *See* 7/25/00 A.M. Tr. at 4–5. Antipsychotic medication may also adversely affect Weston's memory, although Dr. Johnson discounted this possibility. *See* 7/24/00 P.M. Tr. at 50–51; 7/25/00 A.M. Tr. at 4–5. Further, a jury listening to a non-delusional Weston explain his delusional beliefs may be more skeptical than a jury listening to a delusional, unmedicated Weston. In such circumstances, the jury might find it hard to believe that a person with an appropriate affect did not understand the nature and wrongfulness of his behavior at the time of the charged conduct. *See Weston*, 206 F.3d at 21 (Tatel, concurring).

The potential prejudice to Weston regarding his demeanor and potential testimony at trial is of concern to the Court because his ability to present his version of the facts is a critical one. *See Commonwealth v. Louraine*, 390 Mass. 28, 453 N.E.2d 437, 442 (1983). Moreover, if Weston's sanity is at issue, the jury is entitled to consider Weston's demeanor in court. *See id.* Nevertheless, even on this vital question of courtroom demeanor and testimonial rights, courts have not regarded a

defendant's right to refuse medication as absolute. Rather, courts have scrutinized the particulars of a case and taken measures to mitigate the prejudice. For instance, courts have analyzed the distinction between sedatives, that can dull thought processes, and antipsychotics that should restore or improve cognitive function by a mentally ill defendant. *See, e.g., People v. Hardesty*, 139 Mich.App. 124, 362 N.W.2d 787, 797 (1984) ("since it was a matter of speculation how nearly defendant in an undrugged state of mind at trial would reflect his mental state at the time of the offenses, we believe that informing the jury of his drugged condition adequately protected his right to testify"); *State v. Law*, 270 S.C. 664, 244 S.E.2d 302, 306 (1978) ("[T]here is nothing to indicate the medications undermined the appellant's sanity defense. There was much testimony given before the jury regarding the medications and their effect. The jury was well aware of the appellant's mental history and present condition and knew that the appellant's remissive state and calm demeanor at trial were the result of medication.").

The defendant's right to appear before the jury in an unmedicated state may depend upon how closely that state approximates his demeanor at the time of the charged offense. *Cf. State v. Hayes*, 118 N.H. 458, 389 A.2d 1379, 1381–82 (1978). Weston was not taking medication at the time of the charged offense and has deteriorated significantly over the intervening two years. With or without medication, Weston would not appear at trial in the same condition as at the time of the incidents at the U.S. Capitol.²⁰ Therefore, Weston's right to appear before the jury in an unmedicated state is less absolute than

it might be were his current condition like his condition at the time of the alleged offense.

The Court recognizes the cautionary statement in *Riggins* that "[e]ven if . . . the Nevada Supreme Court was right that expert testimony allowed jurors to assess Riggins' demeanor fairly, an unacceptable risk of prejudice remained." *Riggins*, 504 U.S. at 138, 112 S.Ct. 1810. However, the Court must evaluate the language in concert with the statements in *Riggins* that an essential government interest can sometimes justify trial prejudice. *See Riggins*, 504 U.S. at 138, 112 S.Ct. 1810 (citing *Holbrook v. Flynn*, 475 U.S. 560, 568–69, 106 S.Ct. 1340, 89 L.Ed.2d 525 (1986)).

C. Weston's Demeanor and Appearance

As indicated, antipsychotic medication raises concerns regarding its possible effect on Weston's demeanor and appearance in front of the jury. Side effects of the medication may alter Weston's reactions in the courtroom, cause uncontrollable movements, or create other changes in behavior that may prejudice Weston. *See Riggins*, 504 U.S. at 141–43, 112 S.Ct. 1810 (Kennedy, J., concurring). Advances in the primary antipsychotic medications and adjunct therapies make such side effects less likely. *See* 5/28/99 A.M. Tr. at 19–20; 7/24/00 A.M. Tr. at 105–06. Additionally, medications that help control side effects are available and Weston will be very closely monitored. In fact, antipsychotic medication is likely to make Weston's affect more, rather than less, appropriate. *See* 7/26/00 A.M. Tr. at 62–63 (Dr. Zonana); 7/25/00 A.M. Tr. at 4, 23–24 (Dr. Johnson).

²⁰ Indeed, it appears that Weston is currently unwilling or unable to discuss his delusions, although he did so freely in the period imme-

diately following his arrest. *See* 5/28/99 A.M. Tr. at 21–22.

D. Weston's Right to Present a Defense, Including an Insanity Defense

Judge Tatel stated in his concurring opinion that “[r]endering Weston nondelusional may impair his ability to mount an effective insanity defense. . . . Were Weston’s testimony the only way for him to present an insanity defense, I would thus have serious doubts about whether the government could involuntarily medicate him.” 206 F.3d at 21 (Tatel, J., concurring). Judge Tatel went on to suggest that Weston’s testimony may not be the only way to present an insanity defense and directed this Court to “review the tapes to determine whether they show Weston in his delusional state, and if so, whether, combined with psychiatric testimony, they would enable defense counsel to mount an effective insanity defense.” *Id.*²¹

Considerable evidence documents the extent and nature of Weston’s delusions. At the July 2000 hearing, Weston’s attorneys cross-examined Dr. Johnson at length about Weston’s delusional system, includ-

ing those delusions that motivated him to go to the U.S. Capitol on July 24, 1998. *See* 7/24/00 P.M. Tr. at 16–48. Further, videotaped interviews with defense expert, Dr. Phillip Resnick, document this delusional system.²² Dr. Resnick interviewed Weston at least six times over approximately twelve hours. Also, one defense expert, Dr. Seymour Halleck, interviewed Weston shortly after the shootings in the presence of a government expert, Dr. Robert Phillips. The tapes and psychiatric reports reviewed by the Court document Weston’s delusional state over several years.²³ However, the tapes do not necessarily focus on the particulars of the alleged offense or the precise details of how Weston’s delusions relate to his alleged actions on July 24, 1998.

Neither the government nor the Court requested that Dr. Johnson or Dr. Daniel render an opinion about Weston’s sanity. However, their reports, which are incorporated herein as if set forth *seriatim*, are replete with evidence of the following: Weston’s mental condition, hospitalizations, and treatment before and after the time of the offenses charged, as well as

21. The Court pursued this issue in open court with counsel for both parties and in sealed proceedings with Weston’s attorneys only. Suffice it to say, without violating the confidentiality of the sealed conversation with Weston’s attorneys, they took the position that it was not Weston’s burden to present evidence on this issue. Further, they maintained that they had no authorization from their client to present any evidence on this issue. The government also claimed that it was not its burden to present evidence on this issue and, likewise, presented no additional evidence on this issue. In view of the unusual posture of this case, pre-arraignment, the federal rules allowing a party to obtain discovery of this type of evidence from a party opponent do not enable the Court to order either side to produce relevant evidence at this time on the issue of insanity. In the event Weston is ever arraigned, however, and serves a Fed. R.Crim.P. 12.2 notice, the parties can ex-

change discovery on this issue and the Court can order a responsibility assessment pursuant to 18 U.S.C. § 4242(a).

22. Even predating the alleged offenses, the Central Intelligence Agency taped an extensive interview with Weston in which he discussed his delusional beliefs at length. *See* 7/24/00 P.M. Tr. at 26–27. *See generally* 7/26/00 P.M. Tr. at 28–36.

23. The videotapes reviewed by the Court include: 1) an interview between Dr. Phillip Resnick and Weston at Central Treatment Facility on January 31, 1999; 2) an interview between Dr. Phillip Resnick and Weston at Central Treatment Facility on March 27, 1999; 3) an interview of Weston conducted at the Central Intelligence Agency’s headquarters in 1996; and 4) a Christmas dinner and gift exchange with Weston and his family in 1997.

evidence of his mental condition at the time of the offense; the deterioration of his mental condition over many years and the knowledge of such deterioration by his family members, friends, and mental health professionals; the relative stabilization of his assaultive and threatening behavior when medicated; that he had not been taking medication for many years preceding his arrest; and that he had a long history of prior hospitalizations and treatment for his mental problems.

Moreover, the reports identify numerous lay witnesses, including family members, who could testify about Weston's behavior, appearance, speech, actions, and extraordinary or bizarre acts by him over a significant period. Also, according to Weston's attorneys, material released by the government on the eve of the competency hearing, pursuant to *Brady v. Maryland*, 373 U.S. 83, 83 S.Ct. 1194, 10 L.Ed.2d 215 (1963), identifies witnesses who observed Weston while he appeared delusional and acting bizarre. At this preliminary stage of the proceedings, and mindful that Weston has never been arraigned, it is the Court's preliminary opinion that the tapes, when combined with psychiatric and lay testimony may allow Weston to mount an effective insanity defense, which would entitle him to an instruction on this issue.²⁴ See 18 U.S.C. § 17(b).

The restoration of Weston's competency could trigger the production of additional relevant evidence from which the Court could supplement its findings on this issue. For instance, if Weston is arraigned, he will then have the opportunity to file a

notice, pursuant to Fed.R.Crim.P. 12.2, that he intends to rely on the defense of insanity and that he intends to introduce expert testimony relating to a mental disease or defect or any other mental condition bearing on the issue of guilt. Upon the filing of such notice and motion by the government, the Court would order a psychiatric or psychological examination of Weston and that a report be filed with the Court pursuant to 18 U.S.C. § 4242(a). Further, discovery by Weston and the government of additional mental health evidence would occur pursuant to Fed. R.Crim.P. 16. Thus, if Weston regains competency and wishes to assert an insanity defense, there may be additional evidence regarding this issue.

E. Summary

There are many uncertainties regarding the effects that medication will have on Weston's demeanor and thought processes because the reaction to medication is unique to each patient. However, the Court rejects Weston's attorneys' contention that this uncertainty precludes the use of medication in this context at this time. To interpret "clear and convincing" evidence as the defense suggests would effectively preclude involuntary medication in every case, since the government could never establish that a given individual would respond in a predictable manner, no matter how high the statistical probabilities.

It is difficult for the Court to determine at this point whether unacceptable trial prejudice would result from the medi-

24. Indeed, courts "have generally taken a liberal approach to the admissibility of evidence in support or contradiction of the affirmative defense of insanity." *United States v. Rezaq*, 918 F.Supp. 463, 466 (D.D.C.1996); see also *United States v. Brawner*, 471 F.2d 969, 994-95 (D.C.Cir.1972); *United States v. Alexander*, 805 F.2d 1458, 1464 (11th Cir.1986) (noting

that a court "should be liberal in admitting testimony (and evidence) regarding the issue of insanity"); *United States v. Samuels*, 801 F.2d 1052, 1056 (8th Cir.1986); *United States v. McRary*, 616 F.2d 181, 184 (5th Cir.1980); *United States v. Ives*, 609 F.2d 930, 932-33 (9th Cir.1979); *United States v. Smith*, 507 F.2d 710, 711 (4th Cir.1974).

cation. Nor is it essential that the Court attempt to resolve all these uncertainties at this stage of the proceedings. *See Weston*, 206 F.3d at 21 (Tatel, J., concurring) (stating that he “see[s] no reason why the potential for side effects would preclude the district court from ordering medication, provided that, should Weston become competent to stand trial, the district court conducts a second hearing to determine the extent to which any side effects Weston is actually experiencing might affect his fair trial rights”); *see also Morgan*, 193 F.3d at 264–65 (“further procedural protection” available post-treatment to assess impact of medication of defendant’s fair trial rights).

As Judge Tatel recognized, “the Constitution entitles a criminal defendant to a fair trial, not a perfect one.” *Weston*, 206 F.3d at 22 (Tatel, J., concurring) (citing *Delaware v. Van Arsdall*, 475 U.S. 673, 681, 106 S.Ct. 1431, 89 L.Ed.2d 674 (1986)). Thus, the correct inquiry at this stage is whether Weston could receive a fair trial, notwithstanding the potential prejudice. There is no reason to conclude, at this time, that involuntary medication would preclude Weston from receiving a fair trial. First, should the medication significantly alter Weston’s demeanor or memory, there is substantial extant information concerning his past and present delusions that would aid the Court in reassessing the impact involuntary treatment might have on Weston’s fair trial rights and aid him in presenting an insanity defense. Second, the Court credits the testimony of the government experts and Dr. Daniel, the independent expert, that the side effects of medication are manageable through adjustments in the timing and amount of the dose, and through supplementary medications. Third, Weston has no absolute right to present himself as he was on the day of the alleged crime, nor could he, with or without medication. As the government

correctly notes, Weston is already in a significantly different mental condition compared with the day of his arrest.

The Court will reassess, upon request, its determination regarding the prejudice to Weston’s fair trial rights resulting from medication when testimony about the actual, not hypothetical, impact of the medication is available. The Court is confident that any such review will not come too late to prevent impairment of Weston’s rights. However, since Weston’s reaction to the medication is, at this point, unknown, by proceeding to medicate him, the government risks the possibility of forfeiting its right to bring Weston to trial. Nevertheless, the Court is reasonably confident, based on the persuasive expert testimony, that any prejudice that might arise would occur with ample time for the Court to revisit these issues.

If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston’s unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.

Moreover, Weston’s treatment with antipsychotic medication will be closely monitored. First, pursuant to the administrative regulations governing the use of involuntary treatment and the accreditation requirements of the Joint Commission on Accreditation of Health Care Organizations, every 30 days Weston’s medication treatment plan will be

reviewed by a non-treating psychiatrist. *See* 7/26/00 P.M. Tr. at 90–91. These 30-day reviews will focus on: (1) the onset, if any, of side effects; (2) any medical problems that may develop; (3) the psychiatrist's use of appropriate lab analyses, such as eye examinations, and liver enzyme tests; and (4) the appropriateness of current dosages. *See* 7/26/00 P.M. Tr. at 91–92. Weston "can ask the hearing officer for an in-person review at any time instead of the 30-day review." 7/26/00 P.M. Tr. at 94. Second, every week at FCI-Butner, a non-treating doctor reviews the medications of all patients in the hospital with an eye toward ferreting out anything unusual and monitoring compliance. *See* 7/26/00 P.M. Tr. at 92. Third, apart from the psychiatrists, pharmacy personnel review dosages and medication combinations on a monthly basis. *See* 7/26/00 P.M. Tr. at 93. Fourth, a report on Weston's treatment shall be provided to the Court every month and the Court is reserving the option of having each report reviewed by an independent expert. *See* 7/26/00 P.M. Tr. at 93. Fifth, Weston's attorneys and family can independently monitor him upon request to the Court. *See* 7/26/00 P.M. Tr. at 94.

CONCLUSION

The Court has found by at least clear and convincing evidence that antipsychotic medication is medically appropriate. Further, considering less intrusive alternatives, antipsychotic medication is essential to prevent Weston from harming others and restore his competency and to bring him to trial. The Court has carefully scrutinized the likely impact of the medication on Weston's fair trial rights and, at this stage, is persuaded that Weston can be medicated without impermissibly infringing on his ability to receive a fair trial. The Court will conduct subsequent eviden-

tiary hearings, as appropriate, to consider the actual effects of the medication on Weston and the related implications on his trial rights.

Accordingly, for the reasons articulated, it is hereby

ORDERED that the Bureau of Prisons is authorized to treat the defendant, Russell Eugene Weston, Jr., involuntarily with antipsychotic medication. The Court will **STAY** this ruling until **March 19, 2001**, at **5:00 P.M.** to enable Weston to file a Notice of Appeal, and thereafter to seek a further stay of the Court's ruling from the United States Court of Appeals; and it is

FURTHER ORDERED that the Bureau of Prisons provide the Court and the parties with a report regarding Weston's treatment every thirty days; and it is

FURTHER ORDERED that the Bureau of Prisons bifurcate the roles of forensic evaluator and treating psychiatrist in this case.

IT IS SO ORDERED.



Richard D. MUDD, M.D., Plaintiff,

v.

**Louis CALDERA, Secretary of the
Army, et al., Defendants.**

No. CIV.A. 97-2946(PLF).

United States District Court,
District of Columbia.

March 14, 2001.

Grandson of Dr. Samuel Mudd, who was convicted by military commission as

UNITED STATES of America,
Appellee,

v.

Russell Eugene WESTON,
Jr., Appellant.

No. 01-3027.

United States Court of Appeals,
District of Columbia Circuit.

Argued May 16, 2001.

Decided July 27, 2001.

Government sought order permitting forcible administration of antipsychotic drugs to pretrial detainee accused of killing guards at United States Capitol, in order to render detainee competent to stand trial. The United States District Court for the District of Columbia, Emmet G. Sullivan, J., 69 F.Supp.2d 99, issued order. The Court of Appeals, 206 F.3d 9, remanded. On remand, the District Court, 134 F.Supp.2d 115, reaffirmed its finding that involuntary treatment was medically appropriate and necessary, and detainee appealed. The Court of Appeals, Randolph, Circuit Judge, held that: (1) antipsychotic drugs were medically appropriate; (2) government's interest in bringing detainee to trial was "essential state policy"; and (3) forced medication was necessary in order to restore detainee's competence, and therefore justified.

Affirmed.

Randolph, Circuit Judge, filed concurring opinion joined by Circuit Judge Sentelle.

Rogers, Circuit Judge, filed concurring opinion.

1. Constitutional Law ⇨268.2(2), 272(2)
Mental Health ⇨51.15, 436.1

Due process liberty interest in avoiding unwanted antipsychotic medication is significant, but not absolute; forcible ad-

ministration of such medication to prisoner or criminal defendant may be permissible despite his liberty interest if such medication is medically appropriate and necessary. U.S.C.A. Const.Amend. 5.

2. Mental Health ⇨436.1

Antipsychotic medication was medically appropriate treatment for paranoid schizophrenic pretrial detainee, potentially warranting forcible administration of medication in order to render detainee competent to stand trial, regardless of detainee's contention that some doctors may have ethical objections to involuntary administration of drugs; consensus in medical profession was that antipsychotic medication was medically appropriate response to detainee's condition. 18 U.S.C.A. § 4241(a).

3. Constitutional Law ⇨255(5), 268.2(2)
Mental Health ⇨436.1

Forced administration of antipsychotic drugs against wishes of detainee or defendant, i.e. overriding of detainee's or defendant's due process right to refuse medication, requires finding that administration of such medication is necessary to accomplish an essential state policy. U.S.C.A. Const.Amend. 5.

4. Mental Health ⇨436.1

Government's interest in bringing to trial paranoid schizophrenic detainee accused of killing federal guards at United States Capitol was "essential state policy" which could potentially support forced administration of antipsychotic drugs; government's general interest in punishing crime was at its height in such circumstances, and was undiminished by option of civil commitment, which did not address retributive, deterrent, or investigative functions of criminal trial. 18 U.S.C.A. § 4241(a).

5. Constitutional Law ⇌268.2(2)

Mental Health ⇌436.1

Forced administration of antipsychotic drugs to paranoid schizophrenic detainee accused of killing federal guards at United States Capitol was justified as necessary to make detainee competent to stand trial, overriding detainee's due process right to refuse medication; trial would serve essential state policy of prosecuting serious crime, there was likelihood that detainee would be rendered competent by drugs, and there was no basis for believing that detainee's ability to testify or to present insanity defense would be impaired. U.S.C.A. Const.Amend. 5; 18 U.S.C.A. § 4241(a).

Appeal from the United States District Court for the District of Columbia (98cr00357-01).

Gregory L. Poe, Assistant Federal Public Defender, argued the cause for appellant. With him on the briefs was A. J. Kramer, Federal Public Defender.

David B. Goodhand, Assistant U.S. Attorney, argued the cause for appellee. With him on the brief were Wilma A. Lewis, U.S. Attorney at the time the brief was filed, John R. Fisher and Ronald L. Walutes, Jr., Assistant U.S. Attorneys.

Before: SENTELLE, RANDOLPH, and ROGERS, Circuit Judges.

Opinion for the Court filed by Circuit Judge RANDOLPH.

Concurring opinion filed by Circuit Judge RANDOLPH, with whom Circuit Judge SENTELLE joins.

Concurring opinion filed by Circuit Judge ROGERS.

RANDOLPH, Circuit Judge:

Under the Fifth Amendment's Due Process Clause there is a "significant liberty interest in avoiding the unwanted adminis-

tration of antipsychotic drugs." *Washington v. Harper*, 494 U.S. 210, 221, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). This appeal requires us to decide whether the government may administer such drugs to a pre-trial detainee against his will in order to render him competent to stand trial.

I.

On July 24, 1998, an assailant armed with a .38 caliber revolver forced his way past security checkpoints at the United States Capitol. He shot and killed Jacob Chestnut and John Gibson, both officers of the United States Capitol Police. He shot and seriously wounded Douglas McMillan, also an officer of the United States Capitol Police. Russell Eugene Weston, himself seriously wounded by gunfire, was arrested at the scene. The federal government indicted Weston on two counts of murdering a federal law enforcement officer, one count of attempting to murder a federal law enforcement officer, and three counts of using a firearm in a crime of violence.

The government wants to try Weston for these crimes but is presently unable to do so because the district court found him incompetent to stand trial. *See United States v. Weston*, 134 F.Supp.2d 115, 117 (D.D.C.2001); 1 Joint Appendix 45-46 (competency order). The district court accepted the conclusion of a court-appointed forensic psychiatrist that Weston suffers from paranoid schizophrenia, and that the severity of his symptoms renders him incapable of understanding the proceedings against him and assisting in his defense, as required to bring a defendant to trial. *See* 18 U.S.C. § 4241(a) (statutory competence requirement); *see also Godinez v. Moran*, 509 U.S. 389, 396, 113 S.Ct. 2680, 125 L.Ed.2d 321 (1993) (constitutional competence requirement). The court committed Weston to the custody of the Attorney General "for treatment in a suitable facili-

ty for a reasonable period of time.” 1 Joint Appendix 46; *see also* 18 U.S.C. § 4241(d).

Weston is currently incarcerated “for treatment” at the Federal Correctional Institute in Butner, North Carolina. He is not being treated. Rather, he was placed in solitary confinement under constant observation when he arrived at FCI Butner and remains there today. The Bureau of Prisons apparently placed him in seclusion to “mitigate [his] dangerousness.” *Weston*, 134 F.Supp.2d at 130. As an Assistant Director of the Bureau explained, Weston’s “mental health seclusion status” is “for very vulnerable inmates, and [is] typically . . . reserved for those who present a substantial danger to themselves or somebody else. . . .” 7/24/00 a.m. Tr. at 59. The district court characterized Weston’s confinement situation as “simply the warehousing of Weston in a psychotic state. It is not treatment; at best it contains dangerousness.” 134 F.Supp.2d at 130–31; *see also* 4 Joint Appendix 103 (Report of court-appointed expert that “the field places severe limitations on the use of seclusion in clinical psychiatry because [it] is considered to be inherently aversive when used for prolonged periods of time.”).

There is treatment available for Weston’s illness and its symptoms in the form of antipsychotic medication. The parties agree that such medication is likely the only treatment that can mitigate his schizophrenia and attendant delusions, and thus restore his competence to stand trial. *See* Brief for Appellant at 5; Brief for Appellee at 12–13. Weston is not currently receiving any such medication because, at a time when he was considered medically competent to make a determination, he refused them. The district court prohibited the Bureau of Prisons from forcibly medicating Weston without a court order.

After two administrative hearings and two district court hearings, the government obtained an order authorizing it to administer antipsychotic medication against Weston’s will. *See United States v. Weston*, 69 F.Supp.2d 99 (D.D.C.1999). The district court held that forcible medication was “medically appropriate” and “essential for [Weston’s] own safety or the safety of others.” *Id.* at 118. It also found that “the government has a fundamental interest in bringing the defendant to trial,” but determined that the dangerousness holding made it unnecessary to decide whether that interest outweighed Weston’s right to refuse antipsychotic medication. *See id.* at 118–19. The court declined to consider Weston’s claim that forced medication would interfere with his right to a fair trial, holding it was not ripe. *See id.* at 107.

A panel of this court reversed and remanded the case to the district court, holding that the district court’s dangerousness finding was not supported by the record. *See United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000) (*per curiam*). The panel also reversed the district court’s determination that Weston’s Sixth Amendment right to a fair trial claim was not ripe, holding that “because antipsychotic medication may affect the defendant’s ability to assist in his defense, postmedication review may come too late to prevent impairment of his Sixth Amendment right.” *Id.* at 14 (citations omitted). The panel also directed the district court to consider Weston’s argument that medical ethics preclude forcibly medicating a defendant to make him competent for trial in a case that might carry the death penalty. *See id.* at 14 n. 3.

On remand, the district court again held that the Bureau of Prisons could forcibly medicate Weston. It concluded that antipsychotic medication was medically appro-

priate and “essential to control and treat Weston’s dangerousness to others.” *Weston*, 134 F.Supp.2d at 127, 131. The district court also held that the “government has an essential interest in bringing Weston to trial” given “the serious and violent nature of the charges, that the immediate victims were federal law enforcement officers performing their official duties, and that the killings took place inside the U.S. Capitol amid a crowd of innocent bystanders.” *Id.* at 132. The court concluded that forcible medication would not interfere with Weston’s right to a fair trial, and could in some respects enhance his ability to exercise that right by improving his mental function. *See id.* at 132–38.

In this appeal, Weston claims that administering antipsychotic drugs against his will violates his Fifth Amendment due process liberty interest “in avoiding unwanted bodily intrusion” and implicates his right to a fair trial. *See* Brief for Appellant at 37–38. In earlier stages of this case, Weston asserted a First Amendment right to freedom from compulsory medication and challenged the Bureau of Prisons’ administrative procedures under the Fifth Amendment’s Due Process Clause.¹ He has not raised either issue here so we do not consider them. We affirm the district court’s conclusion that the government’s interest in administering antipsychotic drugs to make Weston competent for trial overrides his liberty interest, and that restoring his competence in such manner does not necessarily violate his right to a fair trial.

II.

[1, 2] The due process liberty interest in avoiding unwanted antipsychotic medication may be “significant,” but it is not absolute. *See Kansas v. Hendricks*, 521

U.S. 346, 356, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997); *United States v. Salerno*, 481 U.S. 739, 750–51, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987); *Youngberg v. Romeo*, 457 U.S. 307, 320, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982). In *Washington v. Harper* and later in *Riggins v. Nevada*, the Supreme Court recognized that the government may, under certain circumstances, forcibly administer antipsychotic medication to a prisoner or criminal defendant despite his liberty interest, provided such medication is “medically appropriate.” *See Riggins v. Nevada*, 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992); *Washington v. Harper*, 494 U.S. 210, 220, 222–23 & n. 8, 226–27, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). With respect to Weston, there is no doubt that this latter condition has been met.

Whether a proposed course of action is “medically appropriate” obviously depends on the judgment of medical professionals. *See Harper*, 494 U.S. at 231, 233–34, 110 S.Ct. 1028; *Youngberg*, 457 U.S. at 322–23, 102 S.Ct. 2452; *Vitek v. Jones*, 445 U.S. 480, 495, 100 S.Ct. 1254, 63 L.Ed.2d 552 (1980); *Parham v. J.R.*, 442 U.S. 584, 606–07, 609, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979); *Addington v. Texas*, 441 U.S. 418, 429, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979). The district court relied on several experts in concluding that “[a]ntipsychotic medication is the medically acceptable and indicated treatment for Weston’s illness.” *Weston*, 134 F.Supp.2d at 122.

The district court measured the medical appropriateness of antipsychotic medication by examining the capacity of antipsychotic drugs to alleviate Weston’s schizophrenia (the medical benefits) against their capacity to produce harm

1. Weston refers in footnote 9 of his brief to the First Amendment, the Fourth Amendment, and “privacy interests” not attributed to any particular part of the Constitution. He

has supplied no supporting arguments and we therefore will disregard his references. *See, e.g., Washington Legal Clinic for the Homeless v. Barry*, 107 F.3d 32, 39 (D.C.Cir.1997).

(the medical costs, or side effects). *See id.* at 123. Numerous experts testified that antipsychotic medication is the medically appropriate treatment for Weston's illness.² While there are potential side effects,³ the professional judgment of the medical experts was that "each of these potential side effects is generally manageable." *Id.* at 123, 125. The short of the matter is that the record leaves no basis for doubting the district court's conclusion that antipsychotic medication is the medically appropriate treatment for Weston's condition.

Weston claims that the ethical obligations a doctor owes a patient preclude forcible medication in these circumstances. As he sees it, "the question whether the administration of antipsychotic medication is medically appropriate is different from the question whether treatment is therapeutically appropriate." Brief for Appel-

lant at 18. Thus, "[t]he context in which the forced medication issue arises and the state purpose are relevant considerations for the physician to decide whether it is ethical to force-medicate." *Id.* If the state's purpose is to make one competent for trial, Weston argues, then a doctor must consider alternatives such as civil commitment. *See id.* These ethical norms purportedly derive from the Hippocratic Oath and the 1982 United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment. *See* Brief for Appellant at 19.

No source of legal authority—neither Bureau of Prisons regulations, nor the statute governing treatment of incompetent pretrial detainees, nor the Constitu-

2. *See, e.g.*, 8/20/99 a.m. Tr. at 59 (Dr. Johnson testifying that the standard of care for treating schizophrenia is antipsychotic medication); 4 Joint Appendix 103 (Report of Dr. Daniel stating that "[a]ntipsychotic medication is essential to the treatment of psychotic disorders such as schizophrenia. Psychotherapy without antipsychotic medication is not considered to be an effective treatment for schizophrenia."); 7/25/00 p.m. Tr. at 11 (Dr. Deprato's testimony that "[t]he diagnosis of paranoid schizophrenia is appropriately treated with antipsychotic medication"); 7/26/00 a.m. Tr. at 64 (Dr. Zonona's testimony: Question: "To your knowledge is there any hospital in this country that would not attempt to treat this patient with antipsychotic medication to address the illness as you understand it based on the materials that you've had an opportunity to sit in and review?" Answer: "Well, I think that is the standard treatment of choice these days [and] if you don't offer and try to use medication in a situation like this, it is negligent.").

3. There are two types of antipsychotic medication—the "typicals" and the "atypicals." The government proposed to use typicals, which are an older generation of antipsychotics. The district court found:

Typical antipsychotics can produce the following side effects: (1) dystonic or acute dystonic reactions, which involve a stiffening of muscles; (2) acuesthesia, which is restlessness or an inability to sit still; (3) Parkinsonian side effects, which can slow an individual; (4) tardive dyskinesia, which causes repetitive, involuntary tic-like movements of the face, eyelids, and mouth; (5) neuroleptic malignant syndrome ("NMS"), which causes temperature control problems and stiffness; and (6) perioral tremor, referred to as rabbit syndrome because of the mouth movements associated with it.

134 F.Supp.2d at 123. The atypicals, which the government has not ruled out, are newer and "have a more favorable side effect profile." *See id.* at 124. The court found that side effects from atypicals include: (1) Agranulocytosis, which could result in death but for which "there is a highly effective monitoring system to prevent this result"; (2) sedation; (3) weight gain; (4) seizures; and (5) problems with lipid metabolism. *See id.* It appears that antipsychotic medications could also alter Weston's demeanor, emotional affect, and cognitive function. *See* 7/24/00 p.m. Tr. at 49–50; 7/25/00 a.m. Tr. at 22–24; 7/26/00 a.m. Tr. at 62–63.

tion—makes medical ethics relevant to the determination whether the government can forcibly medicate Weston. Even if a particular doctor had ethical objections to administering antipsychotic drugs to a non-consenting patient, this would not undercut the consensus in the medical profession that antipsychotic medication is the medically appropriate response to Weston's condition.⁴

A. Mitigating Dangerousness

A pretrial detainee's liberty interest in avoiding unwanted antipsychotic medication gives way when the medication is essential to mitigate the detainee's dangerousness: "Nevada certainly would have satisfied due process if the prosecution had demonstrated, and the District Court had found, that treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of [the pretrial detainee's] own safety or the safety of others." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810. The district court applied this standard to Weston's situation and twice found antipsychotic medication medically appropriate and essential for his safety or the safety of those around him. See *Weston*, 134 F.Supp.2d at 121–32; *Weston*, 69 F.Supp.2d at 107–10.

On appeal of the district court's first decision, a panel of this court found the record insufficient to support application of the *Riggins* standard. Much of the evidence focused on the government's competency-for-trial justification—which the district court did not adopt—and the limited evidence supporting the dangerousness

justification "indicates that in his current circumstances Weston poses no significant danger to himself or to others." *Weston*, 206 F.3d at 13. The panel relied on the testimony of a Public Health Service physician assigned to FCI Butner that "[g]iven [Weston's] immediate containment situation, I feel confident that we can prevent him from harming himself or others under his immediate parameters of incarceration where he is in an individual room with limited access to anything that he could harm himself with or harm anyone else with, and he remains under constant observation." 2 Joint Appendix 121; *Weston*, 206 F.3d at 13. The panel concluded that involuntary medication was not "essential" for safety and instructed the district court that "[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous." *Id.*

On remand, the district court received additional evidence showing that Weston's condition had deteriorated. In view of this evidence, the court once again found that Weston posed such a danger that medicating him was warranted. We think the previous panel's decision likely precluded that finding. That panel held that Weston's situation in confinement—total seclusion and constant observation—obviated any significant danger he might pose to himself or others. There appears no basis to believe that Weston's worsening condition renders him more dangerous

4. Defense counsel also claims that Weston's decision while he was medically competent not to take antipsychotic medication makes such medication medically inappropriate. See Brief for Appellant at 45. We shall assume arguendo that Weston's previous decision reflects his current informed judgment (which of course is unknowable). Nonethe-

less, withholding of consent does not make a treatment medically inappropriate. In *Harper*, for instance, the inmate reportedly said he "would rather die than take medication," 494 U.S. at 239, 110 S.Ct. 1028 (Stevens, J., separate opinion), but the Court approved the treatment as in the inmate's medical interest.

given his near-total incapacitation. Weston remains in seclusion under constant observation. Absent a showing that Weston's condition now exceeds the institution's ability to contain it through his present state of confinement, the prior decision appears to preclude a finding of dangerousness. See *LaShawn A. v. Barry*, 87 F.3d 1389, 1393, 1395 (D.C.Cir.1996) (en banc) (law-of-the-case and law-of-the-circuit doctrines). We need not determine whether our concurring colleague's different interpretation of the previous panel's decision is correct in view of our affirmation of the district court's competency-for-trial ground of decision. See Concurring Op. of Rogers, J., at 889-90.

B. Restoring Competence to Stand Trial

In *Riggins*, the Court prescribed the conditions sufficient for a dangerousness justification, but explicitly declined to "prescribe . . . substantive standards" for determining when other government interests override a pretrial detainee's liberty interest in refusing antipsychotic medication. See *Riggins*, 504 U.S. at 136, 112 S.Ct. 1810; see also *Weston*, 206 F.3d at 12-13 (also declining to prescribe substantive standards). The Court did, however, suggest that the governmental interest in restoring a pretrial detainee's competence to stand trial could override his liberty interest: "the State might have been able to justify medically appropriate, involuntary treatment with [antipsychotic medication] by establishing that it could not obtain an adjudication of [the pretrial detainee's] guilt or innocence by using less intrusive means." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810.

"The substantive issue involves a definition of the protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it." *Harper*, 494 U.S. at 220, 110 S.Ct. 1028 (quoting

Mills v. Rogers, 457 U.S. 291, 299, 102 S.Ct. 2442, 73 L.Ed.2d 16 (1982)) (internal brackets omitted); see also *Foucha v. Louisiana*, 504 U.S. 71, 116, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992) (Thomas, J., dissenting) ("The standard of review determines when the Due Process Clause . . . will override a State's substantive policy choices, as reflected in its laws."). Weston argues that the appropriate substantive standard is strict scrutiny and that involuntary medication must be "narrowly tailored to achieve a compelling government interest." See Brief for Appellant at 36-37; accord *United States v. Brandon*, 158 F.3d 947, 957 (6th Cir. 1998) (strict scrutiny applies to determination whether governmental interest in medicating nondangerous pretrial detainee to make him competent for trial outweighs liberty interest); *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir.1984) (requiring use of "less restrictive alternatives"); see also *Kulas v. Valdez*, 159 F.3d 453, 455 (9th Cir.1998) (using heightened scrutiny under *Riggins*); *United States v. Sanchez-Hurtado*, 90 F.Supp.2d 1049, 1055 (S.D.Cal.1999) (same); *Khiem v. United States*, 612 A.2d 160, 165-66 (D.C.1992) (as amended on rehearing) (applying *Riggins* and requiring "a showing of overriding justification and medical appropriateness"). The government argues for an arbitrary and capricious standard like that employed to review administrative agency action. See Brief for Appellee at 22-27; accord *Harper*, 494 U.S. at 223, 110 S.Ct. 1028 (applying reasonableness standard to forcible medication of prisoners to mitigate dangerousness); *Weston*, 206 F.3d at 14-15 (Henderson, J., concurring); *United States v. Charters*, 863 F.2d 302, 306 (4th Cir.1988) (en banc) (liberty interest "is protected against arbitrary and capricious actions by government officials"); *United States v. Morgan*, 193 F.3d 252, 262 (4th Cir.1999) ("under *Charters*, the determi-

nation of whether to forcibly medicate a pretrial detainee . . . rests upon the professional judgment of institutional medical personnel, subject only to judicial review for arbitrariness"); *United States v. Keeven*, 115 F.Supp.2d 1132, 1137 (E.D.Mo.2000) (following *Morgan*); cf. *Jurasek v. Utah State Hosp.*, 158 F.3d 506, 511 (10th Cir.1998) (applying *Harper's* reasonableness standard to civilly committed patient); see also *Charters*, 863 F.2d at 312-13 (professional judgment standard from *Youngberg v. Romeo*); *Morgan v. Rabun*, 128 F.3d 694, 697 (8th Cir.1997) (same).

The Supreme Court denied that it had adopted a strict scrutiny standard in *Riggins*. See *Riggins*, 504 U.S. at 136, 112 S.Ct. 1810. It also appeared not to apply a reasonableness test or its various analogues: arbitrary and capricious, rational basis, or exercise of professional judgment. Rather, the opinion's language suggests some form of heightened scrutiny: the emphasis on the severity of infringement antipsychotic drugs impose on an individual's liberty interest, see *id.* at 134, 112 S.Ct. 1810; the reasoning that "forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of *overriding* justification," *id.* at 135, 112 S.Ct. 1810 (emphasis added); the statement that medicating to mitigate dangerousness must be "essential" and that the trial court must consider "less intrusive alternatives," *id.*; and the criticism of the district court's failure to find that "safety considerations or other compelling concerns outweighed *Riggins'* [liberty] interest," *id.* at 136, 112 S.Ct. 1810.

[3] We think the appropriate standard is the one the Court set forth in the penultimate paragraph where it noted the lack of a "finding that might support a conclusion that administration of antipsychotic

medication was necessary to accomplish an essential state policy . . ." *Id.* at 138, 112 S.Ct. 1810. Although that paragraph addressed trial prejudice, it outlines the standard the state failed to meet in ascertaining whether a governmental interest outweighs a right to avoid antipsychotic medication. Accordingly, to medicate Weston, the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy.⁵

1. The Essential State Policy in Adjudicating Criminality

Preventing and punishing criminality are essential governmental policies. The Supreme Court has recognized that preventing crime is a compelling governmental interest. See *Schall v. Martin*, 467 U.S. 253, 264, 104 S.Ct. 2403, 81 L.Ed.2d 207 (1984); *United States v. Salerno*, 481 U.S. 739, 749-50, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987). This interest lies not just in incapacitating dangerous criminals, but also in demonstrating that transgressions of society's prohibitions will be met with an appropriate response by punishing offenders. See *Kansas v. Hendricks*, 521 U.S. 346, 361-62, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997); *Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992). The Court has repeatedly adverted to the government's "compelling interest in finding, convicting, and punishing those who violate the law." *Moran v. Burbine*, 475 U.S. 412, 426, 106 S.Ct. 1135, 89 L.Ed.2d 410 (1986); accord *Texas v. Cobb*, 532 U.S. 162, —, 121 S.Ct. 1335, 1343, 149 L.Ed.2d 321 (2001); *Gray v. Maryland*, 523 U.S. 185, 202, 118 S.Ct. 1151, 140 L.Ed.2d 294 (1998) (Scalia, J., dissenting); *McNeil v. Wisconsin*, 501 U.S. 171, 181, 111 S.Ct. 2204, 115 L.Ed.2d 158 (1991); *Richardson v. Marsh*, 481 U.S.

5. The district court held the government to a clear-and-convincing-evidence burden of

proof. See 134 F.Supp.2d at 121 & n. 12. Neither party challenges this determination.

200, 210, 107 S.Ct. 1702, 95 L.Ed.2d 176 (1987); *Garrett v. United States*, 471 U.S. 773, 796, 105 S.Ct. 2407, 85 L.Ed.2d 764 (1985) (O'Connor, J., concurring).

The Court in *Riggins* recognized the strength of the government's policy in adjudicating criminality when it stated that the government "might" be able to involuntarily medicate a defendant if "it could not obtain an adjudication of [his] guilt or innocence by using less intrusive means," 504 U.S. at 135, 112 S.Ct. 1810, and when it cited Justice Brennan's statement that "Constitutional power to bring an accused to trial is fundamental to a scheme of 'ordered liberty' and prerequisite to social justice and peace," *id.* at 135–36, 112 S.Ct. 1810 (quoting *Illinois v. Allen*, 397 U.S. 337, 347, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970) (Brennan, J., concurring)). We do not believe the Court's use of "might" reflects any tentativeness about whether the government could *ever* justify medicating to restore competence to stand trial. If that were what the Court had in mind we doubt that it would have included the statement. We read "might," rather, as indicating that the interest in adjudicating criminality is not necessarily an essential state policy under all circumstances. *Cf.* *Brandon*, 158 F.3d at 960–61 (no compelling interest in trying man accused of sending a threatening letter; factors relevant to this determination include seriousness of the offense, whether the pretrial detainee is dangerous, and whether the detainee will be released if not tried); *Khiem*, 612 A.2d at 176 & n. 1 (Ferren, J., dissenting from denial of rehearing en banc) ("Whereas the District may have a compelling state interest in force-medicating Khiem [to try him for murder], the District will not necessarily have such an interest in force-medicating pretrial detainees charged with lesser crimes.").

[4] We need not decide under what circumstances trying and punishing offend-

ers is not "essential." The government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers in a place crowded with bystanders where a branch of government conducts its business. The Court made the point in *Salerno*: "While the Government's general interest in preventing crime is compelling, even this interest is heightened when the Government musters convincing proof that the arrestee, already indicted or held to answer for a serious crime, presents a demonstrable danger to the community. Under these narrow circumstances, society's interest in crime prevention is at its greatest." 481 U.S. at 750, 107 S.Ct. 2095; *see also Khiem*, 612 A.2d at 167; *but see Bee v. Greaves*, 744 F.2d 1387, 1395 (10th Cir.1984). The statutory sentences for the crimes Weston is accused of committing—life in prison and death—reflect the intensity of the government's interest in bringing those suspected of such crimes to trial. *See* 18 U.S.C. §§ 1111, 1114.

Weston concedes that in "the ordinary case, the strength of the government's interest in trying a defendant accused of first degree murder is undisputed," but argues that when "the government seeks to forcibly medicate a defendant in order to try him, however, the case is no longer ordinary, because presumptions against forced medication have deep roots in the law." Brief for Appellant at 43. This argument is a reprise of the medical ethics point we considered and rejected in determining whether antipsychotic medication is medically appropriate. It has no more purchase here. The "presumption" against forced medication goes to the importance of Weston's constitutional right to refuse antipsychotic drugs (which we agree is substantial), not to the nature of the government's countervailing interest.

We also do not believe that the "governmental interest in medicating a defendant

in order to try him is diminished . . . by the option of civil commitment." Note, *Riggins v. Nevada: Toward a Standard for Medicating the Incompetent Defendant to Competence*, 71 N.C. L.REV. 1206, 1223 (1993). The civil commitment argument assumes that the government's essential penological interests lie only in incapacitating dangerous offenders. It ignores the retributive, deterrent, communicative, and investigative functions of the criminal justice system, which serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial. Civil commitment addresses none of these interests. In Weston's case, civil commitment would be based on his present mental condition, not on his culpability for the crimes charged: "criminal responsibility at the time of the alleged offenses . . . is a distinct issue from his competency to stand trial." *Jackson v. Indiana*, 406 U.S. 715, 739, 92 S.Ct. 1845, 32 L.Ed.2d 435 (1972); see also 18 U.S.C. § 4241(f) ("A finding by the court that the defendant is mentally competent to stand trial shall not prejudice the defendant in raising the issue of his insanity as a defense to the offense charged, and shall not be admissible as evidence in a trial for the offense charged.").

2. Involuntary Medication is Necessary and there are no Less Intrusive Means

The sole constitutional mechanism for the government to accomplish its essential policy is to take Weston to trial. See U.S. CONST. amend. V (no deprivation of life, liberty, or property without due process). Antipsychotic medication is necessary because, as the district court found, "antipsychotic medication is the only therapeutic intervention available that could possibly improve Weston's symptom picture, lessen his delusions, and make him competent to

stand trial." *Weston*, 134 F.Supp.2d at 132. The government cannot "obtain an adjudication of [Weston's] guilt or innocence by using less intrusive means." *Riggins*, 504 U.S. at 135, 112 S.Ct. 1810.

[5] Although Weston does not propose any alternative means, he claims that the fit between involuntary medication and the government's interest is not sufficiently tight in two respects. First, he argues that the medication will not restore his competence to stand trial because he is not likely to respond to it. Second, he contends that the medication's mind-altering properties and likely side effects will prejudice his right to a fair trial such that the government could not lawfully try him even if his competence were restored. Either way, the argument goes, there is an insufficient probability that forcible medication will satisfy the government's interest.

We will treat what Weston styles the "narrow tailoring" requirement of strict scrutiny as an attack on the "necessity" of antipsychotic medication. In determining whether a governmental interest overrides a constitutional right, courts examine not only the nature of the right and the strength of the countervailing interest, but also the fit between the interest and the means chosen to accomplish it. This inquiry entails a predictive judgment about the probable efficacy of the means to satisfy the interest. In the terms of this case, antipsychotic medication may not be "necessary" if its use will not permit the government to try Weston.

That antipsychotic medication must be necessary to restore Weston's competence to stand trial does not mean there must be a 100% probability that it will produce this result. As the Court has recognized, "necessity" may mean "absolute physical necessity or inevitability" or "that which is only convenient, useful, appropriate, suitable, proper, or conducive to the end

sought.” *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 515 n. 13, 109 S.Ct. 3040, 106 L.Ed.2d 410 (1989) (plurality opinion) (quoting Black’s Law Dictionary); see also *Board of Trustees v. Fox*, 492 U.S. 469, 476–77, 109 S.Ct. 3028, 106 L.Ed.2d 388 (1989). Even narrow tailoring in strict scrutiny analysis does not contemplate a perfect correspondence between the means chosen to accomplish a compelling governmental interest. See *Burson v. Freeman*, 504 U.S. 191, 206–10, 112 S.Ct. 1846, 119 L.Ed.2d 5 (1992) (plurality opinion).

The government has established a sufficient likelihood that antipsychotic medication will restore Weston’s competence while preserving his right to a fair trial. See *Brandon*, 158 F.3d at 960. The district court acknowledged that “it is not certain that the medication will restore Weston’s competency,” but “credit[ed] the . . . testimony of the mental health experts that this outcome is likely.” *Weston*, 134 F.Supp.2d at 132. The government presented evidence that antipsychotic medication mitigated symptoms for at least 70 percent of patients. See 7/24/00 p.m. Tr. at 108–09; 8/20/99 a.m. Tr. at 56; 11/15/00 a.m. Tr. at 57. Dr. Johnson testified that the response rate is probably higher with the atypicals. See 7/24/00 p.m. Tr. at 108–09. The government also provided reason to believe that the probability of restoring competence might be higher in Weston’s case because of Weston’s “relatively little exposure to antipsychotic medication” and his generally positive response to the limited medication he received in 1996. See *Weston*, 134 F.Supp.2d at 122; see also 8/20/99 a.m. Tr. at 56; 7/27/00 a.m. Tr. at 120–21; 4 Joint Appendix 105 (Report of Dr. Daniel).

The small possibility that antipsychotic medication will not make Weston compe-

tent for trial is certainly tolerable considering that antipsychotic medication is the sole means for the government to satisfy its essential policy in adjudicating the murder of federal officers. See *Burson*, 504 U.S. at 207–08, 112 S.Ct. 1846 (emphasizing that the means chosen is the “only way” to satisfy the state’s compelling interest). The district court made the most precise predictive judgment it could in this context. See 8/20/99 a.m. Tr. at 56 (Dr. Johnson’s testimony that “you are unable to predict in the individual case whether that individual will actually respond”).

Weston points out that there is also a possibility that antipsychotic medication could prejudice his right to a fair trial by, for instance, altering his courtroom demeanor, interfering with his recollection and ability to testify, and obstructing his right to present an insanity defense. We agree with the district court that “[t]here is no reason to conclude, at this time, that involuntary medication would preclude Weston from receiving a fair trial.” *Weston*, 134 F.Supp.2d at 137.

The general right to a fair trial includes several specific rights such as the right to be tried only while competent, that is, while able to understand the proceedings, consult with counsel, and assist in the defense. See *Drope v. Missouri*, 420 U.S. 162, 171–72, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975). As we determined, there is a sufficiently high probability that antipsychotic medication will restore Weston’s competence to stand trial. The district court found and the evidence indicates that “a strong likelihood exists that medication will enhance some of Weston’s trial rights, particularly his right to consult with counsel and to assist in his defense.” *Weston*, 134 F.Supp.2d at 133.⁶

6. See 7/24/00 p.m. Tr. at 8 (Dr. Johnson’s testimony that “I would really expect him,

from a mental status standpoint, to be functioning in a much enhanced manner over his

Another aspect of the right to a fair trial is Weston's right to testify and "to present his own version of events in his own words." *Rock v. Arkansas*, 483 U.S. 44, 49, 52, 107 S.Ct. 2704, 97 L.Ed.2d 37 (1987). The defense is concerned that the medication might affect Weston's memory and his capacity to relate his delusions and other aspects of his mental state at the time of the crime, which in turn "may impair his ability to mount an effective insanity defense." *Weston*, 206 F.3d at 21 (Tatel, J., concurring); *see also* 18 U.S.C. § 17 (affirmative defense of insanity). But the record contains no basis to suppose that antipsychotic drugs will prevent Weston from testifying in a meaningful way. Rather, it indicates that medication will more likely improve Weston's ability to relate his belief system to the jury. *See* 7/24/00 p.m. Tr. at 49–51. The benefits of antipsychotic medication in terms of Weston's ability to understand the proceedings and communicate with his attorneys presumably will also translate into an improved capacity to communicate from the witness stand. And although memory loss is a potential side effect, Dr. Johnson testified that she thought "he'd be able to remember his belief system." 7/24/00 p.m. Tr. at 50 (also stating that "I don't think the treatment would impact his memory"); *see also* 7/25/00 a.m. Tr. at 4–5 (Dr. Johnson's testimony that "I don't expect him to lose the memory of his delusional beliefs as a result of treatment").

There is a possibility that the medication could affect Weston's behavior and demeanor on the witness stand such that the

jury might regard his "synthetically sane" testimony as inconsistent with a claim of insanity. As Justice Kennedy put it in *Riggins*, "[i]f the defendant takes the stand . . . his demeanor can have a great bearing on his credibility and persuasiveness, and on the degree to which he evokes sympathy." *Riggins*, 504 U.S. at 142, 112 S.Ct. 1810 (Kennedy, J., concurring). We recognize this small risk, but we see little basis to suppose that the jury will take Weston's testimony (if he decides to testify) as an indication that he must have been sane at the time of the crime, or that he is making it up, or that he deserves no sympathy. There is ample evidence of Weston's history of mental illness and bizarre behavior; the jury's overall impression of Weston will depend as much on this evidence as his testimony.

The district court also correctly held that a defendant does not have an absolute right to replicate on the witness stand his mental state at the time of the crime. *See Weston*, 134 F.Supp.2d at 134. A defendant asserting a heat-of-passion defense to a charge of first degree murder does not have the right to whip up a frenzy in court to show his capacity for rage, nor does a defendant claiming intoxication have the right to testify under the influence. *See Weston*, 206 F.3d at 15 (Henderson, J., concurring). There is little meaningful distinction between these cases and medication-induced competence to stand trial. Either way, the defendant's mental state on the stand is different from the mental state he claims to have operated under at the time of the crime. The tolerable level

current psychotic state to the point where I believe his competence could be restored"); *id.* at 9 (Dr. Johnson stating that "I actually firmly believe that treatment with the medication will enhance his ability to follow the issues at the trial"); 7/25/00 a.m. Tr. at 24 (Dr. Johnson's testimony that "successful treatment would result in a decrease in his delusional thinking, hopefully a resolution of

that, an increase in his attention, ability to concentrate, and a change in his affect, or the way his mood appears to someone who is looking onto the situation. His preoccupation with his delusional system has led me to believe at various points that he has also experienced some hallucinatory phenomena, and I would expect that to resolve.").

of difference no doubt increases in a case like this where there is substantial evidence of mental state other than the defendant's present appearance.

Weston will not have to rely solely on his own testimony to show his state of mind on July 24, 1998. Involuntary medication therefore stands little chance of impairing his right to present an insanity defense. There is extensive documentation and testimony concerning Weston's delusional system, his history of mental illness, and his "behavior, appearance, speech, actions, and extraordinary or bizarre acts . . . over a significant period." *Weston*, 134 F.Supp.2d at 135–36. Multiple experts have examined Weston and presumably may testify. Many of these examinations no doubt related to his trial competence, but "[t]he tapes and psychiatric reports . . . document Weston's delusional state over several years." *Id.* at 135. There is also a taped interview in which Weston discussed his delusional beliefs with the Central Intelligence Agency. *See id.* at 135 n. 22. Given the wealth of expert and lay testimony and other documentation the district court described, *see id.* at 135–36, Weston's insanity defense does not stand or fall on his testimony alone.

A third trial right that could be implicated by antipsychotic medication is Weston's right to be present at trial in a state that does not prejudice the factfinder against him. *See Estelle v. Williams*, 425 U.S. 501, 503–04, 96 S.Ct. 1691, 48 L.Ed.2d 126 (1976); *Illinois v. Allen*, 397 U.S. 337, 338, 344, 90 S.Ct. 1057, 25 L.Ed.2d 353 (1970). To the extent the medication alters Weston's demeanor, courtroom behavior, or reactions to events in the courtroom, it may cause the jury to see Weston in a state that might seem inconsistent with a claim of insanity. It could also produce a flattened emotional affect that could convey to the jury a lack of remorse, a critical con-

sideration if this case proceeded to sentencing.

Here again the record indicates that medication will likely enhance rather than impair Weston's right to a fair trial. Dr. Johnson stated that medication "will alter [Weston's demeanor] to the extent that it will be more a return to his baseline non-psychotic state. I would anticipate he would have less blunting or flattening of his affect. He would be able to respond more appropriately from an emotional standpoint with his facial expression than he is now." 7/24/00 p.m. Tr. at 8; *see also* 7/25/00 a.m. Tr. at 22–24 (Dr. Johnson agreeing with the proposition that, with medication, Weston's "expressions potentially could be more appropriate to the context of what's occurring in the courtroom"; also, her testimony that "[i]t is the patient who is over-medicated or whose side effects are not managed who would demonstrate an increased lack of responsiveness").

The possibility of side effects from antipsychotic medication is undeniable, but the ability of Weston's treating physicians and the district court to respond to them substantially reduces the risk they pose to trial fairness. The district court found that Weston's doctors can manage side effects in a number of ways: "the Court credits the testimony of the government experts and Dr. Daniel, the independent expert, that the side effects of medication are manageable through adjustments in the timing and amount of the doses, and through supplementary medications." *Weston*, 134 F.Supp.2d at 137; *see also* 11/15/00 a.m. Tr. at 125 (Dr. Daniel's testimony that antipsychotic medications have side effects but "[g]enerally they can be treated or an adjustment made in the medication, or the medication replaced with a different one. There's generally a way to deal with the side effects."); 4 Joint Appendix 102 (Statement in Dr. Daniel's re-

port to the district court that “the side effects can most often be managed or an alternative course of treatment provided to the benefit of the patient. General experience with antipsychotics, particularly the newer medications, indicates that given their benefits they are reasonably safe and well-tolerated.”). As the Court wrote in *Harper*, the “risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals.” 494 U.S. at 233, 110 S.Ct. 1028.⁷

The district court also has measures at its disposal: “If Weston is medicated and his competency is restored, the Court is willing to take whatever reasonable measures are necessary to ensure that his rights are protected. This may include

informing the jurors that Weston is being administered mind-altering medication, that his behavior in their presence is conditioned on drugs being administered to him at the request of the government, and allowing experts and others to testify regarding Weston’s unmedicated condition, the effects of the medication on Weston, and the necessity of medication to render Weston competent to stand trial.” *Weston*, 134 F.Supp.2d at 137. Weston is free to propose other options.

There is a very high probability that involuntary medication will serve the government’s essential interest in rendering Weston “competent to stand trial in a proceeding that is fair to both parties.” *Brandon*, 158 F.3d at 954.⁸ Given the lack

7. Antipsychotic drugs have progressed since Justice Kennedy discussed their side effects in *Riggins*. There is a new generation of medications having better side effect profiles. See *Weston*, 134 F.Supp.2d at 134 (citing Justice Kennedy’s concurrence and writing that “[a]dvances in the primary antipsychotic medications and adjunct therapies make such side effects less likely”); Paul A. Nidich & Jacqueline Collins, *Involuntary Administration of Psychotropic Medication: A Federal Court Update*, 11 No. 4 HEALTH LAWYER 12, 13 (May 1999) (“[I]n light of the progress made in the development of new antipsychotic medications since the Supreme Court’s *Riggins* decision in 1992, the courts should revisit this issue with an open mind.... [Because of new atypicals,] the fear of side effects should not weigh heavily in the decision whether to treat pretrial detainees or civilly committed persons with antipsychotic medication against their will when that treatment is medically appropriate.”). Although the government presently plans to medicate Weston with the older generation of typicals, it could switch to the newer atypicals if side effects from the typicals threaten to impair his right to a fair trial. The district court analyzed the side effects of both. See *Weston*, 134 F.Supp.2d at 123–25. Dr. Johnson testified that Weston cannot be treated with atypicals unless he agrees to take them orally. See 7/24/00 a.m. Tr. at 108–09. The parties dispute whether Weston would so agree. When Weston origi-

nally withheld consent to antipsychotic medication, he indicated that he would comply with court-ordered medication. See 5/28/99 a.m. Tr. at 3.

8. Although the bulk of Weston’s fair trial argument relates to the narrow tailoring aspect of his Fifth Amendment substantive due process argument, he makes a fleeting reference to an independent right to a fair trial in arguing for strict scrutiny: “Weston’s Fifth and Sixth Amendment rights to a fair trial are also at stake because the forced administration of antipsychotic medication may ‘have a prejudicial effect on [Weston’s] physical appearance at trial’ and have an adverse effect on his ‘ability to participate in his own defense.’” Brief for Appellant at 37. To the extent this cursory reference suffices to raise this claim, this is not the occasion to evaluate it. Whether antipsychotic medication will impair Weston’s right to a fair trial is best determined when the actual effects of the medication are known, that is, after he is medicated. (This is in contrast to the narrow tailoring component of Weston’s bodily integrity claim, which requires a predictive judgment now.) As Judge Tatel stated in the previous panel opinion, “the difficulty inherent in predicting how a particular drug will affect a particular individual may well lead the district court to conclude that it cannot make this determination about Weston without first medicating him. In that event, I see

of alternative means for the government to satisfy its essential policy, we cannot demand more.

III. Guardian *ad Litem*

Weston also appeals the district court's refusal to appoint a guardian *ad litem*. The district court concluded that it lacked authority to appoint a guardian and expressed uncertainty about what function a guardian would perform if appointed. *See* 7/24/00 a.m. Tr. at 2–3.

We need not decide whether the court had discretion to appoint a guardian and, if so, whether it abused that discretion in declining to exercise it. The issue is not relevant to the outcome of this case. If the guardian consented on Weston's behalf, the government presumably may medicate him. *See* Reply Brief for Appellant at 24–25 (stating that a guardian “would effectively stand in Weston's shoes” and that “Weston's counsel also explained at a hearing that a guardian could take the position that the guardian should do as the guardian saw fit with Weston—which would include allowing medication”); *see also* 7/27/00 a.m. Tr. at 108–09. If the guardian withheld consent, we are in the same position as without a guardian: the government's interest in restoring Weston's competence to stand trial outweighs his liberty interest. If the guardian issue is otherwise relevant, Weston has failed to show it.

* * * * *

Because antipsychotic medication is medically appropriate and is necessary to accomplish an essential state policy, the

no reason why the potential for side effects would preclude the district court from ordering medication, provided that, should Weston become competent to stand trial, the district court conducts a second hearing to determine the extent to which any side effects Weston is *actually* experiencing might affect

district court's order permitting the government to forcibly medicate Weston is

Affirmed.

RANDOLPH, Circuit Judge, with whom Circuit Judge SENTELLE joins, concurring:

I write separately because I believe *United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000), our first decision in this case, may have embodied a serious error.

Concluding that Weston was not sufficiently dangerous to warrant forcibly medicating him, the panel wrote that “in his current circumstances Weston poses no significant danger to himself or to others.” *Weston*, 206 F.3d at 13. This was so because Weston was confined to a room, under constant observation and had no access to anything he could use to harm himself or others. *See id.* The upshot, the panel concluded, was that “[i]f the government advances the medical/safety justification on remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous.” *Id.*

This standard puts the government in an unnecessary quandary. If Weston were no longer confined to a room and under constant surveillance, he would be dangerous and, presumably, could be medicated. However, because the government cannot medicate him while he is carefully confined—and therefore, not dangerous—it cannot release him into the general pre-trial detention population without incurring substantial risks. The result: the

his fair trial rights.” *Weston*, 206 F.3d at 21 (Tatel, J., concurring). The district court stated that it “will conduct subsequent evidentiary hearings” on this point. *Weston*, 134 F.Supp.2d at 138; *see also United States v. Morgan*, 193 F.3d 252, 264–65 (4th Cir. 1999).

government is all but forced to keep Weston in isolation, a condition almost everyone agrees is detrimental to Weston's long-term mental health.

The statutes—18 U.S.C. §§ 4241–4247—provide a far different standard for dangerousness than the prior panel's decision, and represent not only the good judgment of Congress and the President, but also the Judicial Conference of the United States which “after long study by a conspicuously able committee, followed by consultation with federal district and circuit judges,” proposed the legislation. *Greenwood v. United States*, 350 U.S. 366, 373, 76 S.Ct. 410, 100 L.Ed. 412 (1956). Under § 4246, a person is to be held and treated if “his *release* would cause a substantial risk of bodily injury to another person or serious damage to property of another.” 18 U.S.C. § 4246(d) (*italics added*). Thus, the question on Weston's first appeal should not have been whether he was dangerous given the manner in which he was confined, but whether he was dangerous as a general matter, that is, if he were released from strict confinement and observation.

Our concurring colleague proposes a different reading of the prior panel's decision. Because of the problems just discussed, I hope her view eventually prevails even though the language of that opinion, quoted above, does not seem to support her.

ROGERS, Circuit Judge, concurring:

I write separately on two points: the findings necessary for forcible administration of medication in a pretrial context, and the determination of dangerousness to support such governmental intrusion.

First, following the instruction in *Riggins v. Nevada*, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992), the court applies a “form of heightened scrutiny,” Opinion at 880, in considering a number of factors for balancing the interests of the

government and the defendant. Succinctly put, to medicate Weston against his will, “the government must prove that restoring his competence to stand trial is necessary to accomplish an essential state policy.” Opinion at 880. The substantive analysis that the court employs encompasses, however, at least three distinct determinations. To allow the government forcibly to medicate a defendant prior to trial with antipsychotic drugs, the district court must find that: (1) an “essential state policy” is at issue, *Riggins*, 504 U.S. at 138, 112 S.Ct. 1810; (2) “treatment with antipsychotic medication [is] medically appropriate and, considering less intrusive alternatives, essential for the sake of [the defendant's] own safety or the safety of others,” or essential to enable an adjudication of the defendant's guilt or innocence, *id.* at 135, 112 S.Ct. 1810; and (3) the defendant's due process rights are protected. *See id.* at 137–38, 112 S.Ct. 1810.

The district court on remand made these three determinations. *See United States v. Weston*, 134 F.Supp.2d 115, 138 (D.D.C. 2001) (*Weston III*). On appeal, this court addresses the first determination under the heading “The Essential State Policy in Adjudicating Criminality.” Opinion at 880. It addresses the second and third determinations under the heading of “Involuntary Medication is Necessary and there are no Less Intrusive Means.” *Id.* at 882–83. The court provides a separate analysis of each determination. *Id.* at 883–87.

Keeping these determinations separate is important because the Supreme Court has acknowledged that a defendant's liberty interests may outweigh the State's interest. Although indicating that even “a substantial probability of trial prejudice” can be justified if “administration of antipsychotic medication [is] necessary to accomplish an essential state policy,” *Rig-*

gins, 504 U.S. at 138, 112 S.Ct. 1810, the Court has suggested that the defendant's liberty interests would prevail where, for example, the antipsychotic medication impairs the defendant's "ability to follow the proceedings" or to present a defense. *Id.* at 137, 112 S.Ct. 1810; *see also Drope v. Missouri*, 420 U.S. 162, 171-72, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975); *Pate v. Robinson*, 383 U.S. 375, 378, 86 S.Ct. 836, 15 L.Ed.2d 815 (1966). In such circumstances, the government would have the option of seeking civil commitment of the defendant. *See Riggins*, 504 U.S. at 145, 112 S.Ct. 1810 (Kennedy, J., concurring in the judgment); *see generally* 18 U.S.C. §§ 4241-4247; D.C.Code 1981 §§ 21-541 to 21-551. For the reasons set forth by the court, the due process concerns relating to evidence of Weston's mental state and to his competency to stand trial are attenuated. *See* Opinion at 883-87.

Second, the court eschews review of the district court's determination on remand that forced medication was justified because of Weston's dangerousness to himself or others. The court views our decision in *United States v. Weston*, 206 F.3d 9 (D.C.Cir.2000) (per curiam) (*Weston II*) to have "likely precluded" a finding of dangerousness in the absence of evidence that "Weston's condition now exceeds the institution's ability to contain [his dangerousness] through his present state of confinement." Opinion at 879. To suggest that *Weston II* created a "standard" other than the traditional dangerousness standard applicable to pretrial detainees is to misread *Weston II*. *See* Concurring Opinion at 887-88; *see also* Opinion at 879; 18 U.S.C. § 4246(d)(2); 28 C.F.R. § 549.43.

The court in *Weston II* did not "put[] the government in an unnecessary quandary." Concurring opinion at 887. The court's language must be read in context. In stating that "[i]f the government advances the medical/safety justification on

remand, it will need to present additional evidence showing that either Weston's condition or his confinement situation has changed since the hearing so as to render him dangerous," *Weston II*, 206 F.3d at 13, the court was addressing the insufficient evidence of dangerousness in the record before it to support a finding that involuntary medication was "essential" for Weston's safety or the safety of others. *See id.* That evidence showed that as then confined in isolation by the government, Weston did not, in the opinion of the government's treating psychiatrist, pose a significant danger to himself or others. *See id.* What was missing from the district court record was a "searching inquiry into whether less intrusive alternatives [to forced medication] would have been sufficient to control any potential danger posed by Weston to himself and to others." *Id.* at 18 (Rogers, J., concurring in the judgment). The court forewarned, however, that to rely on dangerousness as a basis for forced medication, the government on remand would need to present evidence that showed more than that when confined Weston did not pose a significant danger to himself or others. *See id.* at 13. The government thus remained free to present evidence about the risks of danger that would be created if Weston was not confined in isolation and that less intrusive alternatives to forced medication would be ineffective to control his dangerousness.

The record on remand indicates that the parties and the district court understood what "additional evidence" of dangerousness was required by *Weston II*; none has suggested that the government confronted a "quandary." *See* Br. for Appellee at 28, 38, 41-42; *see also* Opinion at 879. Expert medical testimony was offered on Weston's dangerousness in and out of seclusion, distinguishing between Weston's state of mind and his ability to act on his delusions. *See, e.g.,* Test. of Dr. Daniel, 4

JA at 27-73. To the point, the government now argues in its brief that Weston's "seclusion from the general population is not an 'alternative' to involuntary medication because it has done nothing to quell [his] dangerous behavior," Br. for Appellee at 42, and that "'prolonged use' of seclusion 'brings risk of detrimental effects to the psychological well-being of the patient,' and is 'inherently aversive.'" *Id.* at 43 (quoting expert medical testimony presented on remand). Hence, the government's "quandary" is a creation of the concurrence.



UNITED STATES of America,
Appellee,

v.

Dennis L. WEBB, Appellant.
No. 99-3114.

United States Court of Appeals,
District of Columbia Circuit.

Argued March 9, 2001.

Decided July 27, 2001.

Defendant was convicted of various narcotics offenses by the United States District Court for the District of Columbia, Henry H. Kennedy, Jr., J., and he appealed. The Court of Appeals, Garland, Circuit Judge, held that: (1) alleged Apprendi error, in not submitting, as issue to be decided by jury beyond reasonable doubt, the quantity of drugs that defendant had distributed on three separate occasions to government informant, did not rise to level of plain error; (2) defendant was not entitled to two-point reduction in his base offense level for acceptance of responsibility; (3) error, if any, in permitting government's cooperating witness to testify about his prior drug transactions with defendant

was mere harmless error; and (4) suppression of evidence was not warranted under Leon "good faith" exception to exclusionary rule.

Affirmed.

1. Criminal Law ⇨1035(1)

Alleged Apprendi error, in not submitting, as issue to be decided by jury beyond reasonable doubt, the quantity of drugs that defendant had distributed on three separate occasions to government informant, did not rise to level of plain error, where specific amount involved in each transaction was established by testimony and report of government chemist, as confirmed by tape recordings of conversations between defendant and informant in which drug quantities were discussed, and where defendant did nothing to challenge evidence of drug quantity either at trial or at sentencing. Fed.Rules Cr.Proc. Rule 52(b), 18 U.S.C.A.

2. Criminal Law ⇨1030(1)

Before appellate court can correct error not raised at trial, there must be (1) error, (2) that is plain, and (3) that affects substantial rights; if all three conditions are met, then appellate court may exercise its discretion to notice forfeited error, but only if (4) the error seriously affects fairness, integrity, or public reputation of judicial proceedings. Fed.Rules Cr.Proc.Rule 52(b), 18 U.S.C.A.

3. Criminal Law ⇨1030(1)

When assessing whether error at trial rises to level of "plain error," it is enough, in case where law has changed since time of trial, that error is "plain" at time of appellate consideration. Fed.Rules Cr.Proc.Rule 52(b), 18 U.S.C.A.

4. Courts ⇨96(3)

When precedent of Supreme Court has direct application in case, yet appears

the parties never actually reached one. *Hensley*, 277 F.3d at 540.

[10] In terms of Ms. Thomas, the defendants argue that the court can enforce her part of the settlement since she is not eligible for retirement benefits and her interest “could only be financial.” Defs.’ Opp’n at 5. The plaintiffs counter that “such action would do violence to the unified front that plaintiffs have consistently presented throughout this litigation.” Pls.’ Reply at 4. The plaintiffs insist that “there is no basis in which to precisely determine the amount of Ms. Thomas’ award since she did not agree to a specific sum of money.” *Id.* At this point, the court agrees with the plaintiffs on this issue and does not enforce an agreement as to Ms. Thomas.

Having concluded that there was no binding settlement, the court will give the parties a final opportunity to resolve this case short of trial. In brief, because the defendants agree that a settlement on the monetary component did occur, the court will allow the parties to decide the course of this case. Specifically, the court will give the plaintiffs until September 9, 2002 to notify the court in writing as to whether they accept the defendants’ offer of \$625,000 without any discussion about their retirement status in exchange for dismissing their case in its entirety. If, however, the plaintiffs believe that their retirement status is an integral part of any settlement agreement, they shall notify the court by September 9, 2002 that they are officially rejecting the settlement agreement and the court will convene a status hearing soon thereafter to set this matter for trial.

IV. CONCLUSION

For all these reasons, the court denies the plaintiffs’ motion to enforce the settlement agreement. An order directing the

parties in a manner consistent with this Memorandum Opinion is separately and contemporaneously issued this 25 day of July, 2002.

ORDER

DENYING THE PLAINTIFFS’ MOTION TO ENFORCE THE SETTLEMENT AGREEMENT

For the reasons stated in this court’s Memorandum Opinion separately and contemporaneously issued this _____ day of July, 2002, it is

ORDERED that the plaintiffs’ motion to enforce the settlement agreement is **DE-NIED** unless the plaintiffs file a written notice with the court accepting the defendants’ offer of \$625,000 without retirement benefits by September 9, 2002.

SO ORDERED.



UNITED STATES of America

v.

**Russell Eugene WESTON,
Jr., Defendant.**

No. CRIM.A.98-357.

United States District Court,
District of Columbia.

Aug. 2, 2002.

Government sought order permitting forcible administration of antipsychotic drugs to pretrial detainee accused of killing guards at United States Capitol, in order to render detainee competent to

stand trial. The District Court, 134 F. Supp.2d 115, order drug administration and detainee appealed. The Court of Appeals, 255 F.3d 873, affirmed. Thereafter, government moved for extension of treatment period. The District Court held that expert testimony, reports on progress of detainee, and court's own observations supported extension of treatment period.

Treatment extension granted.

Criminal Law ¶625.15

Expert testimony of physician, progress reports from facility where pretrial detainee was being held, and trial court's observation of detainee, supported 120-day extension of treatment of detainee with antipsychotic drugs, to determine if detainee could become competent to stand trial for killing of United States Capitol guards. 18 U.S.C.A. § 4241(d).

Ronald Walutes, Jr., U.S. Attorney's Office, Civil Division, Washington, DC, for U.S.

A. J. Kramer, Gregory Lawrence Poe, Federal Public Defender for D.C., Washington, DC, for Russell Eugene Weston, Jr.

ORDER

SULLIVAN, District Judge.

On August 1, 2002 this Court heard testimony and argument with respect to the government's request to extend the defendant's treatment for an additional 120-day period pursuant to 18 U.S.C. § 4241(d). Upon consideration of the uncontroverted testimony of the government's expert witness, Dr. Sally Johnson, which the Court credits, the uncontroverted monthly progress reports from the But-

ner Facility, which the Court also credits, as well as the Court's own observations and interactions with the defendant at the Butner Facility in June of 2002 and in open court over the past two days, this Court is persuaded by clear and convincing evidence that the defendant's mental health condition is improving, although he currently lacks the requisite capacity to proceed to trial. The Court further credits Dr. Johnson's opinion that there is a substantial probability that the defendant will attain the capacity to permit the trial to proceed within the foreseeable future, which, in her opinion, could be a year or two from the time that the defendant's medication commenced. Had the government requested an extension of medication for an additional year, the Court would have granted that request based upon the uncontroverted evidence and testimony in this case.

Accordingly, the government's request to continue medication for an additional 120 days is hardly unreasonable in the opinion of this Court, especially in view of the opinion of Dr. Johnson that the defendant could attain the requisite mental capacity to proceed to trial at any time within the one to two year window that she predicts. In reaching this decision, the Court has read and interpreted the apparent conflicting subsections of 18 U.S.C. § 4241 in tandem to avoid any absurd result. The Court is further persuaded by the authorities submitted by the government that the Court's decision is reasonable considering all of the circumstances of this most unusual case.

Therefore, it is hereby

ORDERED that the government's request to extend the defendant's treatment for an additional 120-day period from today's date pursuant to 18 U.S.C. § 4241(d) is **GRANTED**; it is

FURTHER ORDERED that the monthly progress reports shall continue through that period; it is

FURTHER ORDERED that the next hearing in this case shall be held on **November 19, 2002 at 1:00 p.m.**; it is

FURTHER ORDERED that in order to minimize the impact of holding such hearings on the treatment of the defendant, the next hearing shall be held at the Butner facility in North Carolina; it is

FURTHER ORDERED that although the Court, the prosecution, defense counsel, and the defendant shall all be present at Butner, a video presentation of that proceeding will be displayed for public viewing in the U.S. District Courthouse in Washington, D.C. in a courtroom to be determined.

IT IS SO ORDERED.



**SALISBURY COVE ASSOCIATES,
INC., d/b/a Atlantic Brewing
Company, Plaintiff,**

v.

**INDCON DESIGN (1995), LTD., North-
ern Brew Systems, Darryl Gaudreau,
Barrie Miller, Brad Miller, Laurence
D.T. Johnson, and Milton, Johnson,
Defendants.**

No. Civ. 01-211-BC.

United States District Court,
D. Maine.

June 27, 2002.

Buyer brought suit against Canadian seller and installer of bottling machine and

against Canadian attorney and law firm involved in transaction. Attorney and law firm moved to dismiss for lack of personal jurisdiction and improper venue. The District Court, Gene Carter, J., accepted reasons set forth in report and recommendation of United States Magistrate Judge Kravchuk, holding that: (1) buyer failed to establish that attorney and law firm purposefully availed themselves of Maine forum so as to support exercise of specific personal jurisdiction on breach of fiduciary duty and legal malpractice claims; and (3) venue was also improper against attorney and law firm.

Motion to dismiss granted.

1. Federal Civil Procedure ¶1825

When facing a motion to dismiss for lack of personal jurisdiction, the plaintiff bears the burden of establishing that jurisdiction is proper. Fed.Rules Civ.Proc. Rule 12(b)(2), 28 U.S.C.A.

2. Federal Courts ¶96

When an evidentiary hearing is not held to determine whether personal jurisdiction exists, the plaintiff must make a prima facie showing of jurisdiction through citations to specific evidence in the record. Fed.Rules Civ.Proc.Rule 12(b)(2), 28 U.S.C.A.

3. Federal Civil Procedure ¶1825

When facing a motion to dismiss for lack of personal jurisdiction, the plaintiff must produce affirmative proof beyond the pleadings. Fed.Rules Civ.Proc.Rule 12(b)(2), 28 U.S.C.A.

4. Federal Civil Procedure ¶1835

On motion to dismiss for lack of personal jurisdiction when no evidentiary hearing is held, plaintiff's properly supported proffers of evidence are accepted as true and disputed facts are viewed in a

to refiling on this count at such time as the Court directs.



UNITED STATES of America

v.

**Russell Eugene WESTON,
Jr., Defendant.**

No. CR.A. 98-357(EGS).

United States District Court,
District of Columbia.

May 1, 2003.

In criminal prosecution for murder of Capitol police officers in which defendant had been found incompetent to proceed to trial, government moved for additional one-year extension of defendant's hospitalization to restore him to competency. The District Court, Sullivan, J., held that, in light of uncontroverted expert evidence that there was substantial probability that defendant could be restored to competency in foreseeable future, extension would be granted.

Motion granted.

1. Mental Health 438

To justify extended commitment for reasonable time period to restore defendant to competency to stand trial, government must prove, by clear and convincing evidence, that a substantial probability exists that the continued administration of antipsychotic medication will result in a defendant attaining the capacity to permit the trial to proceed in the foreseeable future. 18 U.S.C.A. § 4241(d)(2).

2. Mental Health 438

Government's request for additional year-long commitment of defendant, who had been hospitalized for four years, was reasonable in attempt to restore him to competency to stand trial, in light of uncontroverted testimony of expert that there was substantial probability that defendant would regain competency in foreseeable future; Bureau of Prisons had proceeded cautiously in increasing defendant's dosage of antipsychotic medications to avoid undesirable side effects, defendant had shown progress, doctors intended to treat defendant with at least two additional antipsychotic medications requiring trial periods of four to six months each, and charges against defendant were for murder. 18 U.S.C.A. § 4241(d)(2)(A).

Ronald Walutes, Esq., David Goodhand, Esq., Assistant United States Attorneys, Washington.

A.J. Kramer, Esq., Federal Public Defender, Gregory L. Poe, Esq., Assistant Federal Public Defender, Washington.

George B. Walsh, United States Marshal, United States Courthouse, Washington.

Harley G. Lappin, Director, Federal Bureau of Prisons, Washington.

Dr. Cary N. Mack, Clinical Psychologist, Deputy Chief of Psychiatry, Health Services Division, Federal Bureau of Prisons, Washington.

MEMORANDUM OPINION AND ORDER

SULLIVAN, District Judge.

INTRODUCTION

Pending before the Court is the government's motion pursuant to 18 U.S.C.

§ 4241(d)(2)(2000) to extend defendant's hospitalization for an additional period of one year in order to continue his medical treatment. The Court is charged with determining, in the first instance, whether the government has met its burden of proving that a substantial likelihood exists that Mr. Weston will regain competency within the foreseeable future. If the Court determines that the government has indeed offered sufficient proof, it must address the question whether the requested additional period of one year is reasonable.

In support of its motion, and relying upon 18 U.S.C. § 4241(d)(2), the government contends that "there is a substantial probability that . . . [defendant] will attain the capacity to permit the trial to proceed" within the proposed period of time. Gov't. Mot. at 1. Mr. Weston opposes the government's request, arguing primarily that there is no evidentiary basis on which to grant the motion and no support in legislative or case law for the proposition that one year is a reasonable period of time as a matter of "predictive judgment." Def.'s Opp'n at 3-4.

Upon consideration of the motion, the response and reply thereto, as well as oral arguments and the relevant statutory and case law governing the issues, it is by the Court hereby

ORDERED that the government's motion is **GRANTED** and that Mr. Weston's hospitalization and treatment are continued for an additional period of one year from **November 19, 2002**, the date of the filing of the pending motion, until **November 19, 2003**; and it is further

ORDERED that a supplemental evidentiary hearing is scheduled for **June 17, 2003, at 10:00 a.m.**, in Courtroom # 1 of the United States District Court for the District of Columbia to consider further evidence relating to defendant's medication since **November 19, 2002**, his response to

further medication and any current opinions on the issue of his attainment of competency or lack thereof and his prognosis for attainment of competency to participate in future legal proceedings.

BACKGROUND

Procedural History

On October 9, 1998, defendant Russell Eugene Weston, Jr. was charged in a six-count indictment with murdering two United States Capitol Police Officers and attempting to murder a third officer on July 24, 1998.

On April 22, 1999, the Court ruled that Mr. Weston was incompetent to stand trial and ordered him committed to the custody of the Attorney General "for treatment in a suitable facility," pursuant to 18 U.S.C. § 4241(d). The Court's order further provided that antipsychotic medication could not be administered to Mr. Weston without the prior approval of the Court.

On May 5, 1999, Mr. Weston was admitted to the Health Services Division of the Federal Correctional Institute in Butner, North Carolina ("Butner"). Following his admission to Butner, he refused to voluntarily take the antipsychotic medication prescribed by Dr. Sally Johnson of the Bureau of Prisons ("BOP"), a psychiatrist in the United States Public Health Service tasked with Mr. Weston's case.

On March 6, 2001, following (1) several administrative and judicial hearings, (2) an interlocutory appeal of this Court's first ruling authorizing the defendant's involuntary treatment with antipsychotic medication, (3) a multi-day evidentiary hearing following a remand for further factfinding, and (4) the preparation and submission of a report from a court-appointed expert this Court authorized the BOP to involuntarily treat the defendant with antipsychotic medication. 134 F.Supp.2d 115, 116 (D.D.C.2001). This decision was ultimate-

ly affirmed by a panel of the United States Court of Appeals for the District of Columbia Circuit. 255 F.3d 873, 877 (D.C.Cir. 2001). Thereafter, the U.S. Supreme Court denied defendant's petition for a writ of *certiorari* to review the Circuit Court's ruling. Accordingly, the BOP began treating the defendant with antipsychotic medication on January 30, 2002.

Status reports were submitted each month thereafter and, on or about June 6, 2002, the government requested a 120-day extension under 18 U.S.C. § 4241(d) for the purpose of continuing Mr. Weston's course of treatment with antipsychotic medication. Mr. Weston objected to continued commitment and requested an evidentiary hearing.

On August 1, 2002, the Court held such a hearing and heard uncontroverted testimony from Dr. Johnson. The status reports submitted by the BOP to the time of the hearing, along with various institutional documents relating to Mr. Weston, were admitted into the evidentiary record.

On August 2, 2002, the Court issued an order granting the government's request to extend Mr. Weston's treatment for an additional 120-day period under 18 U.S.C. § 4241(d) (with the additional period commencing on August 2, 2002). *See United States v. Weston*, 211 F.Supp.2d 182 (D.D.C.2002). In its order, the Court scheduled a hearing for November 19, 2002, at Butner. *Id.*

On October 24, 2002, the government filed a motion and requested an additional one-year extension under 18 U.S.C. § 4241(d). Defendant opposed that motion.

The Court, Mr. Weston, counsel for the parties, Dr. Johnson, and a court reporter were present at the November 19, 2002 hearing at the Butner facility. The proceedings also were broadcast live in Court-

room # 5 at the United States Courthouse in the District of Columbia. Dr. Johnson testified at the November 19, 2002 hearing and BOP records and status reports relating to Mr. Weston and his treatment were introduced into evidence.

At a status hearing on November 26, 2002, the Court set a schedule for the parties to submit proposed findings of fact and conclusions of law with respect to the government's request for a one-year extension of the commitment period under 18 U.S.C. § 4241(d). Counsel for the defendant consented to continued medication of the defendant pending resolution of the pending motion. Counsel for the defendant also requested and received a modification of the schedule and additional time within which to file the required pleadings for compelling personal reasons.

FINDINGS OF FACT

Pursuant to this Court's March 6, 2001 order, the BOP has submitted reports regarding Mr. Weston's treatment every thirty days. A review of these progress reports reveals Mr. Weston's steady improvement as a result of treatment with antipsychotic medication.

In the BOP's first status report, dated March 1, 2002, the BOP stated that Risperadol, an antipsychotic medication, was initially administered to Mr. Weston on January 30, 2002. Following the onset of treatment, according to the report, Mr. Weston "gradually demonstrated an increased amount of interaction with staff." On February 28, 2002, for example, "he indicated his willingness to utilize the telephone to speak with his family; something that he had been unwilling to do secondary to extreme paranoia during his entire period in custody with" the BOP. The report observed that Mr. Weston "can talk fairly rationally about the day to day issues regarding his care; however, extended conversations continue to reveal gran-

diose and paranoid delusional ideation.” Accordingly, the report stated the defendant was tolerating his medication “well, without observable side effects” and had shown “some positive response.” The report concluded that Mr. Weston remains incompetent to stand trial, adding that “[w]e remain optimistic, however, that with continued treatment there is a substantial likelihood that his competency can be restored.”

In its April 4, 2002 report, the BOP explained that the defendant “continues to show positive response to treatment at this time.” In this regard, the report focused on the fact that defendant had made use of both his television and his radio and had “requested a copy of the Bible.” The report additionally noted that Mr. Weston had placed a call to, and requested a visit with, his attorneys. Furthermore, the report observed that Mr. Weston “has not experienced any side effects from [his] medication and has demonstrated good compliance.” The report ultimately found that, despite the progress, “there is sufficient evidence to determine that delusional thinking is still present in regard to his legal situation.” According to the report, in “extended conversations regarding [Mr. Weston’s] medical status, he does verbalize some inaccurate and probable delusional ideas about the status of his injuries and the potential for correction of some of his medical problems.” The report also stated that Mr. Weston “continues to have some grandiose ideas about his identity and capacities On extended discussions, it is evident that he still harbors some delusional ideas with paranoid and grandiose characteristics.” The report concluded that, “with continued treatment there remains a substantial likelihood that Mr. Weston’s competency to stand trial can be restored.”

The May 4, 2002 report stated that Mr. Weston remained in seclusion. Risperadol

and Neurotin continued to be administered for some time. According to the report, “[a]s the month of April progressed, it appeared that Mr. Weston had experienced maximum benefits from his trial of Risperadol and the decision was made . . . to change his antipsychotic to Seroquel . . . with the dose being tapered upward.” According to the report:

The decision to change antipsychotic medication followed continued review of Mr. Weston’s mental status. He had demonstrated what was viewed as an initial positive response to the Risperadol, and as noted in previous reports, had resumed verbal interactions with staff and appeared more alert. Over time, however, he appeared to adapt to the medication and no additional benefits in regard to decreasing the symptoms of his psychosis were noted. Throughout that same period of time, he seemed to become increasingly preoccupied with his medical status In view of the fact that he did not appear to be making additional gains in the resolution of his psychosis, the decision was made to initiate a trial of a different antipsychotic.

The report stated that, as with the prior medication, Mr. Weston did not experience any side effects due to Seroquel and appeared to be tolerating the change relatively well. With respect to Mr. Weston’s competency to stand trial, the fourth status report noted that the defendant “still appears to harbor delusional ideas about his situation,” but he “appears willing to speak with his attorneys by phone and in person,” and he has not “express[ed] specific delusional ideas about them at this time.” The report concluded that the BOP doctors “continue to believe that with treatment there is a substantial likelihood that his competency can be restored,” but that because of the recent switch to Se-

roquel, the defendant “will need to be monitored on this medication for a period of at least a few months to determine his responsiveness.”

In its June, 2002 report, the BOP highlighted Mr. Weston’s positive response to treatment with the new antipsychotic medication. It stated that, “[w]ith the change of antipsychotic medication . . . Mr. Weston has again shown increased willingness to talk with staff.” It further noted that “Mr. Weston tolerated the change in medication without any problem” and “is not demonstrating any side effects from the medication treatment at this time.” According to the report, while Mr. Weston continued to “express some grandiose ideas about his abilities and the abilities of his attorneys, and his family members,” in contrast to the previous month, he did not demonstrate “overt anxiety.” The status report did note that Mr. Weston’s “delusional ideas impair his understanding of the legal process and his options within that process,” but added that “with treatment there is a significant likelihood that [his] competence can be restored in the foreseeable future.”

The fifth BOP status report, dated July 1, 2002, found that Mr. Weston remained in seclusion, had a decreased willingness to exercise, and “often reclines on his bed under his covers. His hygiene remains poor[.]” The report stated that Mr. Weston “continues to express his belief that he is competent to stand trial[.]” a position inconsistent with that of Dr. Johnson and Mr. Weston’s attorneys. The report added that “at times he appears to present information that is inconsistent with the reality of how recent events have happened.” The report recognized that Mr. Weston’s delusions remained intact but that “[f]or the most part he does not overtly verbalize his delusional ideas.” The report stated that “[i]t is our opinion that

Mr. Weston has not yet regained his competency to stand trial.” It added that “with continued treatment there is a significant likelihood that his competence can be restored in the foreseeable future.”

On August 1, 2002, Dr. Johnson testified before the Court at a hearing on the then pending motion to extend medical treatment. As of that date, Mr. Weston showed more expression, smiled more often in appropriate circumstances, engaged with the Butner staff more frequently, and was better able to carry on a coherent conversation. Transcript of August 1, 2002 hearing (“8/1/02 Tr.”), at 22. Dr. Johnson chronicled the improvements resulting from Mr. Weston’s continued treatment:

Improvement in his affect or mood; a broader range of affect; increased ability to relate to people and to interact verbally and socially; an increased interest in his own well-being and in looking out for his interests; an increased willingness to maintain contact with individuals by use of the telephone; an increase in having more stimulation from civilization, as evidenced in an interest in having access to a radio or television. He’s also now able to accurately comment on things that are going on in his environment, and he has recognized the degree of illness in some patients in the hallway with him when he never seemed to have any interest or obligation or ability to talk before.

Id. 35.

Bureau of Prison reports for the months leading up to the November 19, 2002 status hearing detailed Mr. Weston’s progress with the antipsychotic medication. Reports submitted in September, October and November, 2002 noted improvements in defendant’s condition. In the September report, Dr. Johnson concluded that defendant “continues to show a positive

response to his antipsychotic medication treatment.” In the October report, the BOP stated that the defendant had become increasingly autonomous in his functioning. The report concluded by stating that the defendant was “tolerating medication treatment well” and continuing to “show some improvement as treatment with antipsychotic medications continues.” Dr. Johnson stated that there was a “substantial likelihood” that Mr. Weston would “regain competency in the foreseeable future.” In its November submission, the BOP reported that Mr. Weston’s mood was “okay” and that his affect showed a range consistent with the content of conversations. Mr. Weston did not appear to be overly anxious or worried and denied anxiety, depression or suicidal and homicidal ideation. He followed current affairs and did not appear to be suffering from hallucinations. The November report stated that Mr. Weston “has shown considerable improvement in his mental status due to treatment with Seroquel and it appears the increase in dosage may have been useful in...decreasing the symptoms of his illness.” With respect to a possible trial, Mr. Weston’s evaluators noted that, while defendant had not regained his competence, there was a “substantial likelihood” that he would regain it in the “‘foreseeable future.’” Despite the improvements, the report noted that Mr. Weston continued to suffer from delusions.

Dr. Johnson testified at the November 19, 2002 hearing. During the course of the proceedings, she stated her opinion that there is a “substantial possibility in the foreseeable future that Mr. Weston will attain the capacity to permit the trial to proceed.” (11/19/02 Tr. 11–12.) Dr. Johnson defined “foreseeable future” as being twelve months, stating “that is my definition or understanding of what I would view as a time period to be considered the foreseeable future in treatment with Mr.

Weston with the medication regimens that we would like to utilize with him.” (11/19/02 Tr. 12.) She noted that the twelve month period was predicated on the BOP’s plan to finish Mr. Weston’s current medication at its maximum dose and then to utilize at least two other medications in similar four- to six-month trials. *Id.* 18–19, 26, 29–30, 74. As Dr. Johnson explained, “we can only deliver that treatment as we are delivering it by gradually increasing the dose of a particular medication and monitoring his response, and then making a determination whether we need to change the treatment regimen for additional responsiveness, or because he didn’t respond” *Id.* 36.

While Mr. Weston continued to suffer delusions, Dr. Johnson noted that he had improved enough via treatment with antipsychotic medication that the BOP staff were prepared to transfer him out of his seclusion unit into the “open population” (11/26/02 Tr. 3.) He had not yet been transferred, however, because he had not agreed to this plan. *Id.* 4.

Dr. Johnson also chronicled improvement *vis a vis* Mr. Weston’s delusions. As she noted, though the defendant’s “thought disorder” did continue to “impact on how well” he “work[ed] with his attorneys,” she considered it significant that when the defendant was “confronted” about his delusions, he would “stop and think about what it is he’s saying and why it is someone else might not have the same point of view” (11/19/02 Tr. 37–38.) This, Dr. Johnson noted, was “a change in his way of looking at his thought process” *Id.*

Dr. Johnson concluded by reiterating her optimism that the defendant’s competency would be restored in the reasonably foreseeable future, because “he continues to show changes in his symptom picture in the direction of improvement” *Id.* 69. She

cautioned, however, that “[t]he treatment process . . . isn’t magic, it’s not overnight. We’ve been exceptionally careful in adjusting his doses to minimize side effects. He’s been very compliant, but we don’t want to jeopardize that by going too fast and having him develop side effects.” *Id.* 104. As she summed up her opinion and the opinions of the BOP medical staff, “I’ve been impressed with [Mr. Weston’s] gradual progression [and] if you were to poll the staff about the change in Mr. Weston, most of them see it to be remarkable.” *Id.* 105.

The Court also factors into the decision-making process its own observations of the defendant at the November 19, 2002 Butner hearing. For the past four and one half years, this Court has interacted with the defendant at various Court hearings in the District of Columbia and the Butner facility. At the November 19, 2002 hearing, the Court observed the defendant to be more focused and attentive during that hearing than at any prior hearing. The defendant responded appropriately in response to a greeting from the Court and responded affirmatively by nodding “yes” when the Court noted that he had gained weight since the last hearing. When questions were answered “yes” by Dr. Johnson regarding the defendant, he also responded affirmatively by nodding “yes.” The defendant also appeared to communicate freely with his attorneys although the Court will hasten to add that it had no insight as to the subject of those attorney-client communications.

The Court rejects the defendant’s suggestion that Dr. Johnson is “simply guessing as to the outcome of Mr. Weston’s individual case.” Def.’s Proposed Findings of Fact and Conclusions of Law, at 18. Dr. Johnson’s current opinion that there is a substantial probability that the defendant will be restored to competency in the

foreseeable future is based on her extensive experience (including the fact that she has been qualified as an expert in the fields of competency restoration and forensic psychiatry “over a hundred times.”(8/1/02 Tr. 22)). Further, she opined that Mr. Weston’s improvement via treatment with antipsychotic medication is “tracking” the restoration path that she has witnessed in other patients. 8/1/02 Tr. 67–68.

This Court also rejects the defendant’s argument that Mr. Weston’s “delusions are unabated and apparently have expanded in some ways.” Def.’s Proposed Findings of Fact and Conclusions of Law, at 14. At the November, 2002 hearing, Dr. Johnson articulated her understanding of what an expansion of delusions on the part of Mr. Weston would entail. She stated that an expansion of delusions would involve the defendant “bring[ing] new issues, or players in with alternative explanations or expanded explanations” (11/19/02 Tr. 84). In Dr. Johnson’s opinion, simply relabeling something that he already has expressed . . . isn’t necessarily an expansion.” It is her view that relabeling his delusions, “returning to the same kind of ideas,” is all that the defendant has done. *Id.* 65. The Court credits Dr. Johnson’s opinion.

CONCLUSIONS OF LAW

In *Jackson v. Indiana*, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435 (1972), the United States Supreme Court held that “a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to be tried cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future.” *Jackson*, 406 U.S. at 739, 92 S.Ct. 1845. In *United States v. Deters*, the court stated that

[i]f [the defendant cannot understand the proceedings because of a mental disease or defect], the defendant is incompetent to stand trial, and the court must order the defendant hospitalized for a reasonable period of time (up to four months) for the purpose of determining whether there is a “substantial probability” that the defendant will become competent in the foreseeable future. If the court finds that this substantial probability exists, the defendant’s step-two confinement may be extended for an “additional reasonable period of time” to allow him to gain the capacity for trial.

United States v. Deters, 143 F.3d 577, 580 (10th Cir.1998).

The governing statute, 18 U.S.C. § 4241(d), is clearly consistent with the *Jackson* proposition and provides, in relevant part:

if a court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the Attorney General. The Attorney General shall hospitalize the defendant for treatment in a suitable facility—

(1) for such a reasonable period of time, not to exceed four months, as is necessary to determine whether there is a substantial probability that in the foreseeable future he will attain the capacity to permit the trial to proceed; and

(2) for an additional reasonable period of time until -

(A) his mental condition is so improved that trial may proceed, if the court finds that there is substantial probability that within such additional

period of time he will attain the capacity to permit the trial to proceed; or (B) the pending charges against him are disposed of according to law;

whichever is earlier.

If, at the end of the time period specified, it is determined that the defendant’s mental condition has not so improved as to permit the trial to proceed, the defendant is subject to the provisions of the “civil commitment statute,” or section 4246.

18 U.S.C. § 4241(d).

[1] To justify extended commitment pursuant to 18 U.S.C. § 4241(d)(2), the government must prove, by clear and convincing evidence, that a substantial probability exists that the continued administration of antipsychotic medication will result in a defendant attaining the capacity to permit the trial to proceed in the foreseeable future. *Cf. Riggins v. Nevada*, 504 U.S. 127, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992) (contemplating application of a clear and convincing evidence before antipsychotic medication may be forcibly administered) (citing *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979) (Due Process Clause allows civil commitment of individuals shown by clear and convincing evidence to be mentally ill and dangerous)); *Riggins*, 504 U.S. at 139, 112 S.Ct. 1810 (Kennedy, J., concurring) (government must make an “extraordinary showing” before antipsychotic medication may be forcibly administered); *United States v. Weston*, 255 F.3d 873, 880 n. 5 (D.C.Cir.2001) (“The district court held the government to a clear-and-convincing-evidence burden of proof [citing 134 F.Supp.2d 115, 121 & n. 12 (D.D.C.2001)]. Neither party challenges this determination”), *cert. denied*, 534 U.S. 1067, 122 S.Ct. 670, 151 L.Ed.2d 583 (December 10, 2001). Once the government has met the “substantial probability” standard, it may

extend commitment for a reasonable time period.

[2] The Court credits the uncontroverted testimony of Dr. Johnson that there is a substantial probability that Mr. Weston will regain competency in the foreseeable future. It is therefore tasked with determining whether the requested period of one additional year is consistent with the provisions of 18 U.S.C. § 4241(d)(2)(A). In light of the fact that the BOP has thus far proceeded with caution in increasing Mr. Weston's dosage, the representations of BOP doctors that they intend to treat Mr. Weston with at least two additional antipsychotic medications requiring trial periods of four to six months each and, finally, the nature of the offenses charged, the Court, in the exercise of its discretion, is persuaded that the requested year-long commitment period is reasonable. The Court's conclusion is supported by the existing case law. *See, e.g., Jackson*, 406 U.S. at 738, 92 S.Ct. 1845 (stating that due process concerns require that "the nature and duration of commitment bear some reasonable relation to the purpose"); *Little v. Twomey*, 477 F.2d 767, 770 (7th Cir. 1973) (holding that "a 'reasonable period of time' must be to some extent equated with the gravity of the offense involved"), *cert. denied*, 414 U.S. 846, 94 S.Ct. 112, 38 L.Ed.2d 94 (1973). Indeed, in the words of Dr. Johnson, "[t]he treatment process... isn't magic, it's not overnight. We've been exceptionally careful in adjusting his doses to minimize side effects." *Id.* 104. In the Courts' view, the request to extend treatment for an additional year is hardly unreasonable. In proceeding cautiously and prudently, serious side effects have been minimized by the mental health physicians. Thus, progress has been made

to restore Mr. Weston's competency in his first period of intense treatment for his illness.

Conclusion

Upon consideration of the uncontroverted testimony of the government's expert witness, Dr. Sally Johnson, which the Court credits, the uncontroverted monthly progress reports from the Butner Facility, which the Court also credits, as well as the Court's own observations and interactions with the defendant at the Butner Facility in November, 2002, this Court is persuaded by at least clear and convincing evidence that the defendant's mental health condition is improving, although he currently lacks the requisite capacity to proceed to trial. The Court further credits Dr. Johnson's opinion that there is a substantial probability that the defendant will attain the capacity to permit the trial to proceed within the foreseeable future, which, in her opinion, could be a year from the time that the pending motion was filed. Accordingly, the government's request to continue medication for an additional one year period is **GRANTED**. The Court is further persuaded by the authorities submitted by the government that the Court's decision is reasonable considering all of the circumstances of this case.¹

An appropriate Order accompanies this Memorandum Opinion.

ORDER

Upon consideration of the government's Motion Pursuant to 18 U.S.C. § 4241(d)(2), the response and reply thereto, the evidentiary record herein, as well as oral arguments and the relevant statutory and case law governing the issues, it is by the Court hereby

1. In reaching its conclusion, the Court has not considered any progress reports filed sub-

sequent to the November, 2002 hearing.

ORDERED that the government's motion is **GRANTED** and that Mr. Weston's hospitalization and treatment are continued for an additional period of one year from **November 19, 2002**, the date of the filing of the pending motion, until **November 19, 2003**; and it is

FURTHER ORDERED that the monthly progress reports shall continue through that period; and it is

FURTHER ORDERED that this **ORDER** is without prejudice to a supplemental evidentiary hearing scheduled for **June 17, 2003 at 10:00 a.m.**, in Courtroom # 1 of the United States District Court for the District of Columbia to consider further evidence of defendant's medication since **November 19, 2002**, his response to further medication and any current opinions on the issue of his attainment of competency or not and prognosis for attainment of competency to participate in further proceedings. By no later than **May 20, 2003** the government shall file an appropriate pleading informing the Court of evidence it plans to adduce at the hearing on **June 17** to support its request that medication of Mr. Weston should continue until **November 19, 2003**. Defense counsel shall file an appropriate response to the government's submission by no later than **June 3, 2003**; any reply by the government shall be filed by no later than **June 10, 2003**; and it is further

ORDERED that the Bureau of Prisons and the United States Marshal's Office shall transport the defendant from the Butner Medical Facility to attend the hearing in the District of Columbia and house the Defendant in an appropriate facility to insure no interruption in his medication regimen.



John FLYNN, et al., Plaintiffs,

v.

**OHIO BUILDING RESTORATION,
INC., et al., Defendants.**

Civil Action No. 02-0921 (RBW).

United States District Court,
District of Columbia.

May 2, 2003.

Trustees of Employee Retirement Income Security Act (ERISA) plan funds brought action against employers, alleging that employers failed to make contributions to the plan as required by collective bargaining agreement with unions. Employers moved to dismiss or for summary judgment. The District Court, Walton, J., held that: (1) collective bargaining agreement (CBA) between employers and unions did not manifestly express intent by parties that trustees would relinquish rights, accorded by their trust agreement, to bring civil action for delinquent contributions, and be bound by arbitration procedures in CBA, and (2) court could assert personal jurisdiction over employers, under ERISA's nationwide service of process provision.

Motions denied.

1. Federal Civil Procedure ⚖️31

Fairness, not excessive technicality, is the guiding principle under the Federal Rules of Civil Procedure.

2. Federal Civil Procedure ⚖️1831, 2547.1

In a case where the parties dispute facts material to a jurisdictional time limit,

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

UNITED STATES OF AMERICA)	
)	
v.)	Criminal Action No. 98-357
)	(EGS)
RUSSELL EUGENE WESTON, JR.,)	
)	
Defendant.)	
)	

O R D E R

Upon consideration of the government's Motion pursuant to 18 U.S.C. § 4142(d)(2), the response, the reply thereto, the arguments made in open court on March 11, 2004, and for the reasons stated in Court that day, it is by the Court hereby

ORDERED that the government's Motion is **GRANTED**. The Court credits the testimony of Dr. Sally Johnson and the Court is persuaded that the defendant is continuing to make progress as he is less firmly invested in his previous delusions. The Court is further persuaded that the timeline for restoring competency can be an inexact science, thus making this extension appropriate. Therefore, the Court finds that there remains a substantial probability that Mr. Weston will regain competency and, because he is continuing to make progress with the assistance of medication, the Court will Order the continuation of the medication for a period of six months commencing November 19, 2003, and expiring May 19, 2004; and it is

FURTHER ORDERED that a Status Hearing will be held on May 5,

2004 at 10:30 a.m. in Courtroom One.

DATE: March 15, 2004 SIGNED: EMMET G. SULLIVAN
United States District Judge

Notice to:

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houn allegedly caressed the plaintiff's breast, the plaintiff also reported this incident to Sgt. Thomas, Compl. ¶¶ 21–22, and she directly asked Sgt. Thomas what he was going to do about Sgt. Calhoun *Id.* ¶ 22. During this conversation, Sgt. Thomas purportedly burst into laughter and agreed to intercede. *Id.* The plaintiff also reported Sgt. Calhoun's behavior to Deputy Chief Musgrove who told her to go immediately to the internal EEO office of the MPD.⁹ *Id.* at 23; Pl.'s Stmt. at 4. The plaintiff was under Deputy Chief Musgrove's command for a time while she worked in the Sixth District. *Id.* The plaintiff admits that she did not immediately follow Deputy Chief Musgrove's advice because she was concerned that Sgt. Calhoun would be disciplined if she went to the EEO office.¹⁰ *Id.* Based on these facts, this Court concludes that the defendant is not entitled to summary judgment due to the affirmative defense because the defendant has failed to show, by a preponderance of the evidence, that "the plaintiff employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer or to avoid harm otherwise." *Faragher*, 524 U.S. at 778, 118 S.Ct. 2275.

III. Conclusion

For the foregoing reasons, the Court concludes that the plaintiff has established that she was subjected to a hostile work environment resulting from sexual harassment that was created by the actions of Sgt. Calhoun and therefore denies the de-

fendant's motion for summary judgment with respect to that claim. The District of Columbia is also not entitled to summary judgment on the plaintiff's vicarious liability theory based on its assertion of the affirmative defense recognized by the Supreme Court in *Faragher*, 524 U.S. at 777–78, 118 S.Ct. 2275. Finally, the Court further concludes that the plaintiff has failed to establish that she was the victim of retaliation and therefore grants the defendant's motion for summary judgment with respect to that claim.

SO ORDERED on this 9th day of July, 2004.¹¹



UNITED STATES of America

v.

**Russell Eugene WESTON,
Jr., Defendant.**

No. CRIM.A. 98–357(EGS).

United States District Court,
District of Columbia.

July 15, 2004.

Background: Government sought to extend involuntary medical treatment of defendant who was charged with murders of two federal law enforcement officers and

9. The plaintiff is unclear about exact dates, but believes that she reported Sgt. Calhoun's behavior to Deputy Chief Musgrove between July 8, 1998 to August 12, 1998. She is positive that the report was not after August 12, 1998. Pl.'s Stmt. at 4.

10. The plaintiff indicates that she also reported Sgt. Calhoun's behavior to Sgt. Randolph. However, as the plaintiff's statement of dis-

puted material facts reflects, she actually reported Sgt. Calhoun's behavior to Sgt. Randolph on April 20, 1999, after she filed her complaint with the EEO office. See Pl.'s Stmt. at 6.

11. An Order consistent with this Memorandum Opinion was previously issued on June 30, 2004.

attempted murder of third officer, but found incompetent to stand trial.

Holding: The District Court, Sullivan, J., held that defendant's progress, reasonableness of six-month continuation of medication, and medical appropriateness of continued medication supported extension of treatment.

Request granted.

1. Mental Health ⇐436.1

Defendant's continued progress and substantial probability that defendant would attain capacity to permit his trial to proceed within reasonable future, reasonableness of six-month continuation of medication, resulting in involuntary medication period of two years and 11 months, and medical appropriateness of continued use of anti-psychotic medications, despite defendant's weight gain, supported extension of involuntary medical treatment of defendant who was charged with murders of two federal law enforcement officers and attempted murder of third officer, but was found incompetent to stand trial. 18 U.S.C.A. § 4241(d)(2)(A).

2. Mental Health ⇐437

In determining whether period of commitment of defendant found incompetent to stand trial is reasonable, court considers, among other things, the nature of the offense charged, the likely penalty or range of punishment for the offense, and the length of time defendant has already been confined.

Bruce R. Hegyi, Ronald L. Walutes, Jr., U.S. Attorney's Office, Washington, DC, for Plaintiff.

MEMORANDUM OPINION AND ORDER

SULLIVAN, District Judge.

On July 1, 2004, this Court heard testimony and argument with respect to the government's request to extend the defendant's involuntary medical treatment for an additional 180-day period from May 19, 2004, until November 19, 2004, pursuant to 18 U.S.C. § 4241(d). Upon consideration of the uncontroverted testimony of the government's expert witness, Dr. Sally Johnson, which the Court credits, and her uncontroverted monthly progress reports, which the Court also credits, this Court is persuaded by clear and convincing evidence that the defendant's mental health condition is improving, although he currently lacks the requisite capacity to proceed to trial. The Court further credits Dr. Johnson's opinion that there is a substantial probability that the defendant will attain the capacity to permit the trial to proceed within the foreseeable future.

In *Jackson v. Indiana*, the Supreme Court held that "a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed at trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future." 406 U.S. 715, 739, 92 S.Ct. 1845, 32 L.Ed.2d 435 (1972); *see* 18 U.S.C. § 4241(d)(2)(A) (defendant may be treated for a "reasonable period of time" if the court "finds that there is a substantial probability that within such additional period of time he will attain the capacity to permit the trial to proceed"). The Court added "even if it is determined that the defendant probably

A.J. Kramer, Office of the Federal Public Defender, Gregory Lawrence Poe, Crowell & Moring, L.L.P., Washington, DC, for Defendant.

soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.” 406 U.S. at 739, 92 S.Ct. 1845.

I. Continued Progress

[1] While defendant argues that “his delusions about his case remain unchanged,” Dr. Johnson identified the critical questions as (1) “Despite his delusional thinking, with his degree of investment . . . can he also consider the reality of the situation recognizing other people don’t agree with him and proceed through the trial working with his attorney to resolve his case despite his belief set?”; and (2) “[W]hat can he do versus what is he willing to do?” Tr. 5/5/04 at 31; *see* Def.’s Supplemental Proposed Findings of Fact and Conclusions of Law at 5. Dr. Johnson believed that the defendant’s mock trial performance was telling because it demonstrated that when someone other than Dr. Johnson asked him to participate in a “hypothetical” trial, the defendant “did cooperate and he did . . . demonstrate that he could”. Tr. 5/2/04 at 31–32.

After the mock trial exercise, the group facilitator told Dr. Johnson that “if I were going to trial, I would hire Mr. Weston as my attorney.” Tr. 5/5/04 at 18. Specifically, the facilitator reported that Mr. Weston “had actively and successfully participated” in the mock trial and “showed a good understanding of the general trial procedure, the role of the jury, the role of the judge, the role of the defense attorney, the role of the prosecutor, and [Mr. Weston] was able to think about defenses and formulate a defense.” *Id.* After noting that Mr. Weston successfully developed a “technical defense”, Dr. Johnson testified that Mr. Weston’s performance in the mock trial was “probably the biggest step outside of his ability to leave the seclusion area.” *Id.* at 19.

At the July 1, 2004, Hearing, Dr. Johnson reiterated her earlier concern that “the issue that he chooses what he is going to talk about is, in my opinion, as much an issue about whether he actually has the capacity to talk about something.” Tr. 7/1/04 at 21–22. Dr. Johnson also noted that at their joint June 18, 2004, meeting Mr. Weston “was less willing, from my perspective anyway, to discuss [the delusions] with [Dr. Johnson and defense counsel] than he had been in previous meetings.” Tr. 7/1/04 at 30. Dr. Johnson explained that she “had made an effort to have him consider a hypothetical situation and asked a series of questions about what he would do or what he could do, how he would handle it. And he simply refused to answer those questions or to be directly involved in that discussion. And yet at the mock trial . . . he actually demonstrated an ability to think through those very same issues and to verbalize his thinking, to demonstrate his understanding.” Tr. 7/1/04 at 22.

After a subsequent mock trial exercise where Mr. Weston played the role of the prosecuting attorney, Dr. Johnson reported that the group facilitator “found Mr. Weston’s performance to be just as good as it had been in the defense attorney role and indicated that he was able to give a coherent and appropriate . . . opening statement, was able to do the examination and cross examinations and to prepare a closing statement.” *Id.* at 24. Dr. Johnson also noted that the facilitator thought that Mr. Weston effectively identified “the flaws in [the mock defendant’s] alibi and those types of issues, so that he was very attentive to the details of the scenario and able to work within them.” *Id.* at 25.

Dr. Johnson met with the defendant upon his return to Butner Federal Medical Center on July 6, 2004. Johnson Report 7/8/04 at 3. Mr. Weston refused to discuss

the most recent hearing with Dr. Johnson. *Id.* Dr. Johnson reported that “[e]ven simple questions such as whether he could hear the evaluator’s phone testimony, were met with his response of ‘I have the right to remain silent.’” *Id.* This, coupled with Dr. Johnson’s observation that the defendant “is very aware that it is important for him to talk . . . [a]nd he controls that in a number of different ways by not talking or by only talking when his attorney is there” suggests that this Court should weigh Mr. Weston’s mock trial performance more heavily than his refusal to discuss any remaining delusions. Tr. 5/5/04 at 74. The Court credits Dr. Johnson’s testimony that Mr. Weston’s participation in the mock trial was “probably the biggest step outside of his ability to leave the seclusion area” and finds that progress toward the goal of competency is continuing.

Further, the Court credits Dr. Johnson’s opinion that because the medical literature indicated that “if you can document that the person is making continued gains on the medication, . . . the general accepted clinical standard would be to continue the medication trial for at least a year.” Tr. 5/5/04 at 20; *see also* 5/7/04 at 59–60 (“If someone is showing additional responses, or partial response, . . . but if you don’t have a full remission of symptoms, then you can continue to treat with the same drug. And with Clozaril at least . . . you can continue to see additional response.”).

II. Other Considerations

[2] In determining whether the period of commitment is reasonable, the Court considers “among other things, the nature of the offense charged, the likely penalty or range of punishment for the offense, and the length of time the person has already been confined.” *In re Davis*, 8 Cal.3d 798, 106 Cal.Rptr. 178, 505 P.2d 1018, 1025, *cert. denied*, 414 U.S. 870, 94

S.Ct. 87, 38 L.Ed.2d 88 (1973); *see also Jackson v. Indiana*, 406 U.S. at 738, 92 S.Ct. 1845 (“[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”); *U.S. ex rel. Little v. Twomey*, 477 F.2d 767, 770 (7th Cir.) (“a ‘reasonable period of time’ must be to some extent equated with the gravity of the offense involved”), *cert denied*, 414 U.S. 846, 94 S.Ct. 112, 38 L.Ed.2d 94 (1973).

On October 9, 1998, the defendant was charged in a six-count indictment with the July 24, 1998, murders of two United States Capitol Police Officers and the attempted murder of a third officer. On March 6, 2001, this Court authorized the Bureau of Prisons to involuntarily treat the defendant with anti-psychotic medication. *See* 134 F.Supp.2d 115, 116. This decision was affirmed by the Court of Appeals on July 27, 2001. *See* 255 F.3d 873, 887 (D.C.Cir.2001). Following the defendant’s unsuccessful attempt at Supreme Court review, treatment was begun in late-January 2002. If the defendant is ultimately convicted of these offenses, the minimum sentence is life in prison. This Court finds that a six month continuation of medication, resulting in an involuntary medication period of two years and eleven months, in the face of the gravest of offenses—double homicide of law enforcement officers in the government’s place of business—is not unreasonable.

On June 20, 2004, Mr. Weston’s weight was recorded at 317 pounds. Johnson Report 7/8/04 at 2. The defendant has gained 70 pounds since he was initially placed at Butner. Tr. 5/7/04 at 37. A general practitioner brought in to evaluate Mr. Weston described him as “morbidly obese.” *Id.* With regard to this issue, Dr. Johnson has testified that “the principal contributor in his weight gain is clearly his medication

use. There is no doubt about that. It is associated with significant weight gain." Tr. 7/1/04 at 26.

However, Dr. Johnson has also testified that the defendant's "lab work is within normal limits"; he "has not developed any kind of weight related medical problems"; his "sugar is fine . . . his lipid profile is within normal limits"; and his "blood pressure remains normal." Tr. 5/5/04 at 21-22. On July 1, 2004, Dr. Johnson testified that Mr. Weston's "laboratory studies, including his glucose and lipids and all, continue to be entirely within normal limits." Tr. 7/1/04 at 26-27. She noted that "he's still not demonstrating those conditions like high triglycerides, onset of diabetes, for example, that we would be monitoring him for on these medications. He's not developed any of those or indicated any of those at this point." *Id.* at 27. While this Court is troubled by the defendant's weight gain on the anti-psychotic medications, the Court credits Dr. Johnson's testimony and finds that their continued use remains medically appropriate.

Therefore, it is by the Court, hereby

ORDERED that the government's request to extend the defendant's treatment for an additional 180-day period from May 19, 2004, to November 19, 2004, pursuant to 18 U.S.C. § 4241(d) is **GRANTED**; and it is further

ORDERED that the monthly progress reports shall continue through that period; and it is further

ORDERED that the next hearing in this case shall be held on November 10, 2004, at 10:30 a.m. in Courtroom One.



**In re U.S. OFFICE PRODUCTS
SECURITIES LITIGATION.**

Todd Semon, et al., Plaintiffs,

v.

**Jonathan Ledecky and U.S. Office
Products Co., Defendants.**

No. 99-0137.

Civil Action Nos. 98-2731 (RMU), 98-2884(RMU), 98-3063(RMU), 98-0301(RMU), 98 Civ. 7871(SWK) (SDNY), 98 Civ. 8055(SWK) (SDNY), 98 Civ. 8200(SWK) (SDNY), 98 Civ. 8181(SWK) (SDNY), 98 Civ. 8417(SWK) (SDNY).

United States District Court,
District of Columbia.

July 16, 2004.

Background: Stockholders brought action against company and its former chief executive officer (CEO) under federal securities laws for damages arising out of a strategic restructuring carried out by company.

Holdings: Upon defendants' motions to dismiss, the District Court, Urbina, J., held that:

- (1) stockholders' allegations did not give rise to a strong inference of scienter with respect to their securities fraud claim based on charge that company and its former CEO concealed an agreement to enter a restructuring plan with investment firm for at least 6 months until the plan was publicly announced;
- (2) stockholders failed to plead fraud with particularity with respect to their claim for solicitation of proxy by a false or misleading statement or omission; and
- (3) counts alleging fraudulent prospectus and registration statement would be